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Membership roster, services and structure of the State Medical Society of Wisconsin.

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State Medicol Society of Wisconsin

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PUBLICATION INFORMATION

MANUSCRIPTS. Manuscripts will be accepted for consideration with the understanding that they are original, have never before been published, and are contributed solely to the WISCONSIN MEDICAL JOURNAL. Address manuscripts to Medical Editor, Wisconsin Medical Journal, Box 1109, Madison, Wis. 53701.

Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the JOURNAL and are not returned. Submit one original and two carbon copies. Author should retain one carbon copy. Format and style should follow that of the *AMA Style Book and Editorial Manual*. Manuscripts are subject to editorial modification and such revisions as bring them into conformity with JOURNAL style.

Contributors will be sent a copy of their article after it has been edited and set in type for final approval before publication. A form for ordering reprints will accompany the article.

Under ordinary circumstances manuscripts are published about six months following acceptance, and in the order in which they are received.

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Neither the editors nor the State Medical Society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the JOURNAL. In Editorials, the views expressed, if initialed or signed, are those of the writer and not necessarily official positions of the Society.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Feb. 9–11: 8th annual Telemark Symposium and Ski Outing, Indianhead Chapter of Wisconsin Academy of General Practice, Mt. Telemark Ski Chalet, Cable.

Feb. 13–20: Fifth Annual Wisconsin Medical Alumni/Faculty Retreat, Nassau, San Juan, and St. Thomas.

Feb. 18: In-Depth Teaching Program—*At the Bedside*, State Medical Society of Wisconsin and University of Wisconsin Medical Center, St. Mary's Hospital Medical Center, Madison.

Mar. 12–19: Marquette Medical Alumni Association Clinical Conference, Maui Hilton Hotel, Kaanapali Beach, Maui, Hawaii. (Info: Mr. Robert H. Herzog, Exec. Secy., MMAA, 561 No. 15th St., Milwaukee, Wis. 53233)

Mar. 17: In-Depth Teaching Program—*At the Bedside*, State Medical Society of Wisconsin and University of Wisconsin Medical Center, St. Mary's Hospital Medical Center, Madison.

Mar. 19–20: Meeting of Central States Society of Industrial Medicine and Surgery, Play Boy Club, Lake Geneva.

Mar. 27: Third Annual Southeastern Wisconsin Cancer Conference on "Carcinoma of the Ovary," Ramada Sands Inn, Milwaukee. Info: J. J. Gramling, MD, Chairman, St. Joseph's Hospital, 5000 West Chambers St., Milwaukee, Wis. 53210.

Apr. 1–3: Pediatric Immunology—A Conference on Inappropriate Immunity, Department of Postgraduate Medicine of University of Wisconsin Medical Center, Wisconsin Center, Madison.

Apr. 2: Annual Conference, Wisconsin Tuberculosis and Respiratory Disease Association, Pfister Hotel, Milwaukee.

Oct. 17–23: Wisconsin Work Week of Health.

Apr. 3: Annual Meeting, Wisconsin Thoracic Society, Pfister Hotel, Milwaukee.

May 3–5: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 10–12: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Pfister Hotel, Milwaukee.

1971 NEIGHBORING STATES

Feb. 16–19: Refresher Conference for Family Physicians, The University of Iowa Health Center, Iowa City.

Feb. 20–21: PG course and annual meeting, American Academy of Allergy, Palmer House, Chicago. Info: Executive Office, AAA, 756 N. Milwaukee St., Milwaukee, Wis. 53202; tel. (414) 224–6068.

Mar. 15–26: Course in Laryngology and Bronchoesophagology, Eye and Ear Infirmary of the University of Illinois Hospital and the Abraham Lincoln School of Medicine of the College of Medicine, University of Illinois at the Medical Center, Chicago.

Mar. 17: Second International Symposium on Early Disease Detection, University of Chicago's Center for Continuing Education, Chicago, Ill.

Mar. 18–20: Continuation Medical Course in Psychiatry, University of Minnesota, Nolte Center for Continuing Education, Minneapolis, Minn.

Mar. 19–20: Third Annual Conference on Brief Psychotherapy, "Behavior Therapy," Department of Psychiatry and Behavioral Sciences, Chicago Medical School/University of Health Sciences and Mount Sinai Hospital Medical Center, Chicago, Ill.

Mar. 30–Apr. 3: American College of Radiology, St. Louis, Mo.

May 16–19: 131st Annual Convention, Illinois State Medical Society, Arlington Park Towers, Arlington Heights, Ill.

May 17–19: Annual Convention, Minnesota State Medical–Association, St. Paul Hilton Hotel, St. Paul, Minn.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

1971 OTHERS

Feb. 3–7: Annual Scientific Session, American College of Cardiology, Washington, D.C.

Feb. 4–6: Course on "The Esophagus," Ochsner Medical Center, New Orleans, La.

Feb. 10–11: Course in "Hematology," Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Feb. 16–19: PG course—"Surgery of the Hand," University of Colorado School of Medicine, Humphreys Postgraduate Center, Denison Library Building, Denver, Colo.

Feb. 21–26: Annual program, American Academy of Forensic Sciences, Del Webb's Towne House, Phoenix, Ariz. Info: Robert J. Joling, Esq., Program Chairman, 612 Kenosha National Bank Bldg., Kenosha, Wis.; tel. (414) 654–2101.

Feb. 22–24: Seminar on "The Community Practice of Nephrology," American Heart Association's Council on the Kidney in Cardiovascular Disease, Durham and Chapel Hill, N. C.

Feb. 24–25: Course in "Rheumatic Disease," Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Feb. 26–Mar. 3: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Feb. 26–Mar. 5: Twenty-third Annual Congress and Teaching Seminar, International Academy of Proctology, Mexico City, Mexico.

Mar. 1–6: Society for Cryosurgery, Diplomat Hotel and Country Club, Hollywood, Fla. Info: Mary Trueblood, Secretary, Society for Cryosurgery, 30 N. Michigan Ave., Chicago, Ill. 60602.

Mar. 3–4: Course in "Nursing," Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Mar. 7–12: PG course on "Problems and Approaches to the Diagnosis and Management of Cardio–pulmonary Failure," American College of Chest Physicians, Miami Beach, Fla.

Mar. 8–11: 34th annual meeting, The New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La. (Details appear in an ad elsewhere in this issue.)

Mar. 12–19: Sixth Annual Marquette School of Medicine Clinical Conference, Maui Hilton Hotel, Maui, Hawaii.

Apr. 5–7: North American sectional meeting, American College of Surgeons, Montreal, Canada.

Apr. 19–22: American Industrial Health Conference, The Marriott, Atlanta, Ga.

Apr. 30–May 20: Spring Postgraduate Medical Seminar Cruise to the Mediterranean, Department of Postgraduate Medicine of Albany Medical College, New York.

May 7–9: Medical Legal Conference, American College of Legal Medicine, Royal Orleans Hotel, New Orleans, La. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

May 10–12: Annual Meeting, American College of Sports Medicine, Toronto, Canada. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706; tel.: area code 608/262–3632)

May 17–19: Second National Conference on Breast Cancer, American Cancer Society, Century Plaza Hotel, Los Angeles, Calif.; info: Esther Kelley, Professional Education, ACS, Inc., 219 East 42nd St., New York, N.Y. 10017.

May 19–21: Annual "Topics in Internal Medicine" course, University of Florida College of Medicine, Gainesville.

June 7–11: Annual convention, Catholic Hospital Association, Atlantic City, N.J.

June 21–26: Annual General Practice Review, University of Colorado School of Medicine, Estes Park.

Nov. 15–18: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, 307 No. Charter St., Madison, Wis. 53715)

1971 AMA

Mar. 26–27: 24th National Conference on Rural Health, Atlanta Marriott Motor Hotel, Atlanta, Ga.

Apr. 2–3: Fifth National Congress on the Socio–Economics of Health Care, Caesars Palace, Las Vegas, Nev.

June 20–24: AMA Annual Session, Atlantic City, N.J.

Aug. 30–31: Congress on Occupational Health, Jackson Lake Lodge, Wyoming.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 3: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

For listing of other meetings see the **Journal of the American Medical Association.**

Industrial Medicine—Lake Geneva

The Central States Society of Industrial Medicine and Surgery will be meeting at the Play Boy Club in Lake Geneva for its spring meeting, March 19–20, 1971.

A talk and discussion on industrial dermatoses will be given by Sture A. M. Johnson, MD of the University (of Wisconsin) Hospitals, Madison.

William H. Frackelton, MD of Milwaukee will lecture on industrial injuries to the hands. Other speakers will be presenting interesting subjects as well.

Members of the State Medical Society of Wisconsin are invited to attend. Credit will be given to family physicians.

James J. Barrock, MD of Milwaukee is the chairman of the scientific program.

Pediatric Immunology—Madison

Pediatric Immunology—A Conference on Inappropriate Immunity has been scheduled for April 1–3 at the Wisconsin Center in Madison by the Department of Postgraduate Medicine of the University of Wisconsin Medical Center.

Thomas C. Meyer, MD, department chairman, has set the following objectives of the conference:

1. Present the current views of pathophysiology, diagnosis, and treatment of states of inappropriate immunity (i.e., allergy, autoimmunity, and inadequate immunity).

2. Provide interchange of information between practitioner and nationally known educators via small group discussions.

3. Translate the activities of the research worker into action at the bedside and in the clinic.

Topics to be discussed by nine physicians from across the country will include: mechanisms of allergic response, allergy—2001 A.D., pharmacologic suppression of allergic disorders, and the use and abuse of gamma globulin.

For further information contact: Thomas C. Meyer, MD, Department of Postgraduate Medicine, 307 No. Charter St., Madison, Wis. 53706.

Internal Medicine—Florida

The annual "Topics in Internal Medicine" course will be given May 19–21 at the University of Florida College of Medicine.

This program will consist of three days of intensive lectures, seminars, and panels on new and controversial areas of internal medicine.

For complete information and registration forms, write Mark V. Barrow, MD, Division of Cardiology, Department of Medicine, College of Medicine, University of Florida, Gainesville, Fla. 32601.

Mediterranean Cruise

The Department of Postgraduate Medicine of Albany Medical College has announced that reservations are now being accepted for a Spring Postgraduate Medical Seminar Cruise to the Mediterranean April 30–May 20. The 20-day cruise from New York will be aboard the ship "Raffaello" of the Italian Line.

Ports of call include Casablanca, Naples, Genoa, Cannes, Barcelona, and Lisbon.

Faculty of the Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in internal medicine, cardiology, obstetrics and gynecology, pathology, and surgery.

Request has been made for continuation study credit by the American Academy of General Practice.

For information write to: William P. Nelson, III, MD, Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

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Jack H. Hall, M. D., Indianapolis, Ind.
GENERAL PRACTICE

Denis Cavanagh, M. D., St. Louis, Mo.
GYNECOLOGY

John T. Galambos, M. D., Atlanta, Ga.
INTERNAL MEDICINE

Roger F. Palmer, M. D., Miami, Fla.
INTERNAL MEDICINE

Nathan S. Schlezinger, M. D., Philadelphia, Pa.
NEUROLOGY

Ernest W. Page, M. D., San Francisco, Calif.
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For information concerning the Assembly meeting write Secretary, The New Orleans Graduate Medical Assembly, Room 1538, 1430 Tulane Avenue, New Orleans, Louisiana 70112.

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1971 ANNUAL MEETING

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Highlights of Scientific Program

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MONDAY, MAY 10

A.M. PLENARY SESSION—"The Spleen, Organ of Mystery: Clinical Concepts and Management"
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NOON Roundtable Luncheons: INTERNAL MEDICINE, PATHOLOGY, RADIOLOGY

P.M. INTERNAL MEDICINE, PATHOLOGY, RADIOLOGY

TUESDAY, MAY 11

A.M. PLENARY SESSION—"Problems for Everyone"
PRESENTED BY THE SECTION ON GENERAL PRACTICE

NOON Roundtable Luncheons: ALLERGY, DERMATOLOGY, NEUROLOGY, HEMATOLOGY

P.M. GENERAL PRACTICE, ALLERGY, DERMATOLOGY, NEUROLOGY, RESIDENT–INTERN PAPERS

WEDNESDAY, MAY 12

A.M. PLENARY SESSION
PRESENTED BY THE SECTION ON SURGERY

NOON Roundtable Luncheons: ANESTHESIOLOGY, OPHTHALMOLOGY, OTOLARYNGOLOGY, ORTHOPEDICS, SURGERY

P.M. SURGERY, ANESTHESIOLOGY, OPHTHALMOLOGY, OTOLARYNGOLOGY, ORTHOPEDICS

"The Esophagus"—New Orleans

A postgraduate course on "The Esophagus" will be conducted at the Ochsner Medical Center, New Orleans, La., February 4–6.

Replete with outstanding guest lecturers, this course on the esophagus is designed to provide a comprehensive review of the physiopathologic background of the common esophageal problems, together with the presenting clinical manifestations of these conditions and their proper management, both medical and surgical.

This is the first of three annual courses designed to cover the gastrointestinal tract.

Inquiries concerning this course should be directed to: William H. McFarland, Administrator, Alton Ochsner Medical Foundation, Division of Graduate and Postgraduate Medical Education, 1514 Jefferson Highway, New Orleans, La. 70121.

Course in Psychiatry—Minneapolis

The Department of Psychiatry of the University of Minnesota Medical School and the Minnesota Academy of General Practice will present a continuation course in Office Management of the Emotionally Disturbed Patient, March 18–20, at the Nolte Center for Continuing Education on the Minneapolis Campus.

The course is designed for the family practitioner and all other nonpsychiatric physicians. Allen J. Enelow, Professor and Chairman of the Department of Psychiatry at the Michigan State University College of Human Medicine, will be the guest lecturer.

The program is acceptable for 16½ prescribed hours by the AAGP. Fee: $90. Info: Director, Continuation Medical Education, Nolte Center for Continuing Education, University of Minnesota, Minneapolis, Minn. 55455. □

State Medical Society of Wisconsin

SPEAKERS SERVICE

for

COUNTY MEDICAL SOCIETY MEETINGS

and

COUNCILOR DISTRICT MEETINGS

County medical societies are urged to use this service which is now in its eighth consecutive year of operation. Speakers from throughout the state as well as those from the two medical schools and the State Division of Health are available through application to the State Medical Society. Applications must be filed at least 30 days before a meeting in order to qualify the speaker for an honorarium and travel expenses. (No speakers are furnished during April and May.)

All areas of scientific medicine are represented, and societies are urged to arrange for at least four scientific programs per year. Other subjects on which speakers are available include legislation, health insurance, interprofessional meetings, school health, mental health, care of the aged, occupational health, medical press relations, maternal mortality, glaucoma detection, cancer and heart, orthopedic and heart clinics.

Request application forms from Ben R. Lawton, MD, Chairman, Commission on Scientific Medicine, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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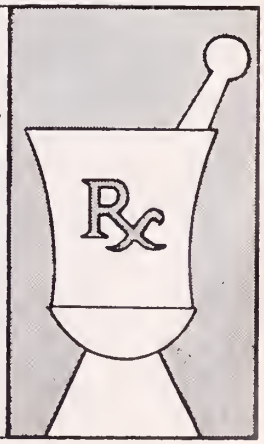

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HOTEL SHERATON–SCHROEDER . . . MAY 10–12, 1971

Sculptures and Paintings (watercolors, acrylics and oils)

WHO MAY EXHIBIT: Any member of the State Medical Society of Wisconsin or his wife.

LIMITED ENTRIES: Up to 3 entries per person.

DEADLINE FOR ENTRIES: All notifications of "Intent to Exhibit" must be received on or before April 1, 1971. (Early notification will be appreciated, so that proper facilities for the entire exhibit can be planned in advance. Mail your entry blank below as soon as possible.)

REQUIREMENTS: (1) All pictures must be framed with wire and screw eyes attached. (2) Works of sculpture must not exceed 24 inches in height. Due to limited exhibit space, these categories must be strictly adhered to. Decisions regarding category eligibility will be left to the discretion of the judge. (3) All entries must be personally delivered to the Upper Level (Balcony) of the Empire Room of the Hotel Sheraton–Schroeder. Use stairway on north side of the main lobby. All entries must be delivered on Sunday, May 9, between 3:00 and 5:00 p.m., and must be picked up in the display area between 3:30 and 5:00 p.m. on Wednesday, May 12. It is hoped that no paintings will be removed from the exhibit before this time.

JUDGING AND AWARDS: Ribbons for first, second, and third places in each of the four categories (sculpture, watercolor, acrylics, and oil painting) will be awarded, plus a "popularity award" based on votes of all those who view the Art Salon.

LIMITED LIABILITY: The submitter must assume full responsibility for work submitted, but every care against damage or theft will be exercised. Guard will be provided during the course of the display.

NOTIFICATION OF INTENT TO EXHIBIT

Mail to Mrs. Richard B. Bourne, 5332 N. Berkeley Blvd., Milwaukee, Wis. 53217 by April 1, 1971.

I plan to submit the following entry or entries for the 1971 MEDICAL ART SALON at the Hotel Sheraton–Schroeder, May 10–12, 1971.

My entry, or entries, will be:

(1) Title _____ ☐ watercolor ☐ acrylic ☐ oil size ____" wide and ____" deep

(2) Title _____ ☐ watercolor ☐ acrylic ☐ oil size ____" wide and ____" deep

(3) Title _____ ☐ watercolor ☐ acrylic ☐ oil size ____" wide and ____" deep

(1) Sculpture ___ Title _____ size ____" wide and ____" high

(2) Sculpture ___ Title _____ size ____" wide and ____" high

(3) Sculpture ___ Title _____ size ____" wide and ____" high

Name: _____ Street: _____

City: _____

PRESIDENT'S PAGE

"The woman's cause is man's: They rise or sink together"

THE WOMEN OF THE AUXILIARY to the State Medical Society of Wisconsin are up to their old tricks again. They are promoting a very worthwhile project; a blood donor program. As usual they have devised a very detailed schedule to make the plan effective.

A blood donor program worksheet has been distributed to each of the County Auxiliary groups. Knowing the women as I do, I am sure that their efforts will be successful.

On behalf of the State Medical Society, I pledge that we will assist and cooperate in every way possible with their project.

The State Medical Society of Wisconsin would exist without the Woman's Auxiliary, but I am sure it would never achieve many of its goals without the help of the ladies. There is no doubt in my mind that many doctors would not be engaged in the Society activities if they were not badgered by their wives. (In other states women prod their men.) Many times in the past I have been reluctant to attend this or that function of the County or State Medical Society, but my dear helpmate has always urged me to attend. I am sure that this situation prevails in many doctors' households.

The Woman's Auxiliary has been engaged directly in many activities in the past such as scholarships for nurses and paramedical students, in promoting health career workshops, immunization programs, preschool vision and hearing screening, contributing to the AMA–ERF funds, sending a senior medical student from the University of Wisconsin to Nicaragua for his preceptorship, participating in the home-centered health care programs (Meal Service and Friendly Visitor Service), safety and environmental health programs, migrant workers and Indian affairs programs, and being involved with legislative affairs as they relate to health.

We know the doctors' wives play a significant part in promoting the general welfare in our state. If you will glance over your local newspaper you will find, time and time again, that some doctor's wife is a participant or a leader in a worthwhile program that enriches our lives and makes our community a better place in which to live.

I do not oppose the woman's liberation movement. My hope is that the doctors' wives will continue to give their loyal support to their physician husbands as they have in the past.

J. W. McROBERTS, MD

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Save Antisubstitution

In the 1950s the American Pharmaceutical Association got behind a drive to enact legislation making illegal the substitution of drugs prescribed by a physician. It had always been considered an unethical practice for a pharmacist to switch brands, when prescribed, but enough pharmacists were taking advantage of available counterfeits to make passage of the laws desirable.

The APhA was so successful that every jurisdiction in the Union except Missouri, Alaska and the District of Columbia has antisubstitution laws. Instead of pressing for 100% success, however, the APhA recently reversed its position and has, by decision of its House of Delegates, undertaken to seek the repeal of the very antisubstitution laws it worked for.

It should be pointed out that, when it promoted the antisubstitution measures, the APhA had the cooperation of the entire pharmaceutical community—from the local retail druggist of ethical character to the largest manufacturer of pharmaceuticals. In its opposite stance, the APhA doesn't even have the support of most retail druggists. According to the survey made by *Drug Topics* magazine, 59% of the retail pharmacists polled oppose repeal of the antisubstitution laws. The National Association of Retail Druggists is on record against repeal, and even some state pharmaceutical groups affiliated with the APhA have not gone along with the national organization.

The APhA contends that changing conditions require the repeal of the antisubstitution laws. In some states a druggist must either refuse to dispense a drug prescribed for a welfare patient that is not on the state-approved formulary, or he must lose money. The APhA insists that if druggists were allowed to substitute at their discretion patients would save money and/or druggists would cease to lose money in the unlikely event that they dispensed a drug for which they were not allowed the full going price.

But there is more—and the more becomes apparent in reading the debate that the decision of the APhA House of Delegates has evoked. Most druggists consider themselves experts on the subject of drugs, as indeed most of them are. They feel that their expertise is not being fully utilized in simply dispensing drugs that a physician orders. The argument usually goes this way, as enunciated by the *American Journal of Hospital Pharmacy:* "The pharmacist is the best qualified to select a brand of a drug if there are *known* differences among brands due to variations in pharmaceutical formulation. . . . The physician's knowledge of the 'performance' of a drug product is usually based on clinical impression rather than on a truly scientific foundation . . . he prescribes a product that he believes from experience will give 'good

results,' but rarely has he compared it with other brands which may give better or poorer results. We certainly would not accept a physician's opinion of a *new* drug after such a haphazard evaluation."

Recognizing the fallacy of their own argument, the same Journal then continued with the statement that the "physician would still be able to exercise this right (to insist on the brand prescribed) in the absence of antisubstitution laws, for the repeal of such laws would serve only to eliminate the state as the middleman in the prescriber-pharmacist relationship."

Another facet of the position of the APhA scores the pharmaceutical manufacturer for proliferating brands and thereby, somehow, abridging the economic welfare of the retail druggist. Since the brands are promoted to doctors, and not to pharmacists, for the most part, the doctors specify brands, and the pharmacist is stuck with having to stock them all—or sharing his profit with a fellow pharmacist who has a more complete inventory. Behind their insistence on the right of the druggist to select the drug product he wants to dispense, we are told by some advocates of repeal, is the hard-nosed desire to protect the economic interest of the patient, and stockholders of pharmaceutical manufacturing companies be damned.

There can be no question that the ethical pharmacist is an indispensable member of the health care team, and no physician would denigrate the function of the druggist. When the antisubstitution laws were written they were aimed at that small minority of the pharmacy profession that engaged in unethical practice. For most druggists the presence or absence of the laws made no difference—and probably would continue to make no difference. But as the health care community grows, there will undoubtedly be a higher number (if not percentage) of unethical pharmacists, and it is necessary that unethical procedures also remain illegal.

There is a vital central issue involved in the debate worthy of medical profession insistence. The physician is responsible for the welfare of the patient, and since he is, he must be certain that what he prescribes is dispensed. The recent nonsense about generic equivalency has apparently encouraged some druggists to make unwarranted assumptions about their capacity to select drug products, given an indication of the drug therapy the physician wants to use. As Food and Drug Commissioner Charles Edwards put it: "It has become increasingly apparent that the drug products which claim to be equivalent and which may satisfy chemical and other analytical tests of equivalency may not in fact be therapeutically equivalent. It is essential, therefore, that the physician know what brand of drug product his patient is using, and that the brand not be switched without his knowledge and consent during the course of treatment."

It is conceivable that when a patient is stabilized on a particular product, he is assured that the same degree of absorption, blood level and duration of action will continue throughout the course of treatment, whereas legalized brand-switching without the doctor's knowledge, either by the same pharmacist or by the patient's having the prescription filled in another pharmacy, could be hazardous to his health. This is not a matter of questioning the druggist's knowledge or his judgment; it is simply a matter of sound medical practice.

It has been pointed out abundantly that the doctor who wishes to delegate product selection to a pharmacist he knows and trusts can do so under the present laws by prescribing generically, by prescribing a brand or "equivalent" or by including a statement on his prescription permitting substitution. By the same token, a pharmacist is always free to discuss a prescription with the prescribing MD and suggest alternative products, or take up the matter of cost if welfare cases are involved. And if a druggist can't get by the doctor's office girl on a matter of such importance, he should utilize medical society grievance procedures.

The antisubstitution laws do indeed protect the patient by minimizing the dilution of responsibility for his treatment. They insulate the pharmacist against the liability for bad results following what may be the exercise of his best judgment. And finally they guarantee the physician that his therapeutic plan will be carried out exactly as he prescribes it. These are all valuable considerations, and they should be preserved at all costs. There is nothing in the present legal structure that must work an economic hardship on the pharmacist; there is nothing that belittles his professionalism. The action of the American Pharmaceutical Association in advocating repeal of the antisubstitution laws was ill-advised, and the medical profession, particularly Wisconsin physicians, must be on guard to preserve these valuable laws until something better comes along.—D.N.G. □

GUIDES FOR SMALLER PLANTS IN INDUSTRY

Suggested Basic First Aid Facilities, Equipment and Supplies for a Small Plant

Tentative Outline—Occupational Health Programs in Small Business Establishments: Guide for Employers, Physicians, Nurses, and First Aid Personnel

These guides are available upon request to the State Division of Health, Department of Health and Social Services, Box 309, Madison, Wis. 53701.

A PILLAR OF FAITH IN MEDICINE
YESTERDAY • TODAY • TOMORROW

Charitable, Educational and Scientific FOUNDATION

OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Every physician should be vitally interested in the opportunities which the Foundation affords toward worthwhile giving in support of projects for the continuance of medical progress.

THE CHARACTER OF THE MEDICAL PROFESSION shapes not only its own destiny but has profound influence on the health and well-being of all the people of Wisconsin. This character finds its root in the centuries-old American belief that individual freedom and well-being hinge on people helping themselves and one another. No where is this credo held in greater respect than among the members of the medical profession. For 129 years the State Medical Society of Wisconsin has reflected this spirit in its activities and services to the public and to member physicians.

In 1954, the State Medical Society of Wisconsin founded the Charitable, Educational and Scientific Foundation to permit physicians and friends of medicine an opportunity to sponsor projects affecting the health of Wisconsin citizens.

Among the many projects which are supported by this method is the Student Loan Fund. Since the integration of the loan fund into the Foundation in 1955, the student loan aspects of the program have grown. At the end of 1970, there were 179 students who had outstanding loans totalling nearly $200,000. The fund still needs at least $100,000 to fill current requests.

Every practicing physician recognizes the unquestionable need for timely aid to the kin of his profession who face unusual financial hardship. Personal hardship strikes at physicians and their families as well as others. Through the Foundation there is an opportunity for professional persons to assist their colleagues who suffer adversity.

The scientific medicine activities of the Foundation include the speakers service for county medical societies, in-depth teaching programs, and the support of research in many fields in cooperation with other agencies.

The Foundation has not neglected the value of learning from the past and the Museum of Medical Progress and Stovall Hall of Health, reconstruction of the Old Fort Crawford Hospital in Prairie du Chien, have made many visitors aware of the role that medicine has and is playing in their lives.

The Foundation is under the direction of a board of trustees composed of the Councilors and Officers of the State Medical Society of Wisconsin and other medical and nonmedical persons. Each component county medical society also designates a representative who is a part of the corporate body, thus providing continuing liaison between the county and state societies in carrying out the affairs of the Foundation.

Financial support of the Foundation is achieved in many ways. Voluntary contributions recommended by the House of Delegates are being supplemented by many physicians and others who find in the Foundation an opportunity for special gifts. Gifts may take a number of forms such as cash, life insurance, securities, books, old medical instruments, stamp and coin collections, works of art, and other artifacts. Some physicians are making the Foundation a beneficiary in their wills. Gifts may be unrestricted, permitting the Trustees to use the funds for any purpose for which the Foundation was created. They may also be restricted or earmarked for specific purposes of interest to the donor. In any event, all contributions to the CES Foundation are deductible for income tax purposes. Contributions are listed monthly in the *Wisconsin Medical Journal.*

WISCONSIN MEDICAL JOURNAL
Vol. 70, No. 1 JANUARY 1971

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

SMS Recommendations to Task Force Included in Major Reorganization of UW Med Center

A major reorganization of the University of Wisconsin Medical Center was approved by the Board of Regents in mid-December.

The approval followed a report by the UW Medical Center Task Force headed by Madison Vice Chancellor Irving Shain.

The task force, appointed by Chancellor Edwin Young in June 1970, was charged with the responsibility of heading off an "internal administrative crisis" in the medical center.

The reorganization will help the University Medical Center "to fulfill its role in providing the people of Wisconsin with the quality of health care they desire," the Regents were advised by the nine-member task force.

During its study the task force invited the State Medical Society to submit comments concerning the function and operation of the medical school.

The Society's recommendations, submitted in November, were noticeably apparent in the task force report.

The Society recommended:

(1) A rebalancing of the major functions of the Medical School—education, research, and service—with emphasis to education in order to achieve adequate results in terms of manpower.

(2) More integration of community physicians and hospitals into the system of medical education to provide the necessary opportunities for basic medical education and medical care experience.

(3) Expansion of the Medical School's horizons to the boundaries of the state and the needs of the public . . . that its teaching programs involve the practicing profession and socio-economic experiments at the community level.

(4) Practicing MDs be brought more closely into contact with the Medical School, perhaps through an advisory committee, thus providing opportunities for practicing physicians around the state to enter into a meaningful academic relationship with the school, including a voice in medical school administration.

(5) The top administrative post have ready access to the Regents of the University via the President.

(6) Possible establishment of an MD in the single position of vice president of the health center and dean of the medical school. This could only be done with adequate provision for assistant administrators and deans.

(7) Great care be exercised to assure the closest cooperation between the Wisconsin General Hospital and the University of Wisconsin Medical School which are inextricably interwoven in the function of medical education.

The Society's communication to the task force was signed by MDs Robert E. Callan, Milwaukee, immediate past president of the Society and the Society's representative on the Advisory Committee on Medical Education of the Wisconsin Legislative Council; Dale V. Moen, Shell Lake, chairman of the

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UW Med Center Dean to Remain at Post

Peter L. Eichman, MD in late December announced that he had withdrawn his resignation as dean of the medical school and director of the medical center at the University of Wisconsin Madison campus.

His announcement followed the approval by the Board of Regents of a task force report on reorganization of the Medical Center.

Dr. Eichman's resignation on June 15, 1970, precipitated the naming of the task force, but the resignation was never acted upon and he continued as dean and director while the task force conducted its studies.

In announcing his decision to remain, Dr. Eichman said, "I look forward to continued cordial and effective cooperation with the chancellor and commit myself to moving the medical center ahead during this period of transition and restructuring."

Dr. Eichman, who was appointed dean and director in 1965, had called his job an administrative "nightmare."

State Legislators Name Leaders for 1971 Session

The State Senate and Assembly, convening for their 80th session on January 19, elected officers and named major committees to conduct the legislative business for 1971.

Officers elected by the State Senate were:

Robert P. Knowles (R—New Richmond), President Pro Tempore
Ernest C. Keppler (R—Sheboygan), Majority Leader
Raymond C. Johnson (R—Eau Claire), Asst. Majority Leader
Fred Risser (D—Madison), Minority Leader
Wayne F. Whittow (D—Milwaukee), Asst. Minority Leader

The Assembly chose the following:

Robert Huber (D—West Allis), Speaker
Joseph Sweda (D—Lublin), Speaker Pro Tempore
Norman Anderson (D—Madison), Majority Leader
Herbert Grover (D—Shawano), Asst. Majority Leader
Harold Froehlich (R—Appleton), Minority Leader
John Shabaz (R—New Berlin), Asst. Minority Leader

Committees of the Senate which are of special interest to health and medicine are:

Finance
Walter G. Hollander (R—Rosendale), Chrm.
James D. Swan (R—Elkhorn), V. Chrm.
Nile W. Soik (R—Whitefish Bay)
Jack D. Steinhilber (R—Oshkosh)
Henry Dorman (D—Racine)

Health and Social Services
James C. Devitt (R—Greenfield), Chrm.
Raymond F. Heinzen (R—Marshfield), V. Chrm.
Everett Bidwell (R—Portage)
Carl W. Thompson (D—Stoughton)
Wayne F. Whittow (D—Milwaukee)

Labor, Taxation, Insurance & Banking
Gerald D. Lorge (R—Bear Creek), Chrm.
Roger P. Murphy (R—Waukesha), V. Chrm.
Milo G. Knutson (R—La Crosse)
Joseph Lourigan (D—Kenosha)
Ronald G. Parys (D—Milwaukee)

Committees of the Assembly of special interest to physicians are:

Health & Social Services
Joseph C. Czerwinski (D—Milwaukee), Chrm.
William Rogers (D—Kaukauna), Vice Chrm.
Harvey L. Dueholm (D—Luck)

Insurance and Banking
John E. McCormick (D—Milwaukee), Chrm.
Robert L. Jackson, Jr. (D—Milw.), V. Chrm.
Edward Nager (D—Madison)
Laurence J. Day (D—Eland)
Paul E. Sicula (D—Milwaukee)
Joseph L. Looby (D—Eau Claire)
Edward Stack (D—Superior)
Gerald D. Kleczka (D—Milwaukee)
Gerald A. Greider (R—La Crosse)
Clarence J. Wilger (R—Elkhorn)
Herbert J. Schowalter (R—Saukville)

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MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

TASK FORCE

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Society's Commission on Hospital Relations and Medical Education; W. D. James, Oconomowoc, Society past president; Gordon Davenport, Jr., Madison, Dane County Medical Society past president and councilor of the SMS; Jerry W. McRoberts, Sheboygan, Society president; and George A. Behnke, Kaukauna, Society president-elect.

The task force recommendations included:

(1) Establishment of a vice chancellor for health sciences to direct an administrative reorganization of the Medical Center.

(2) Changing the center's name to University Center for Health Sciences.

(3) Obtaining financial support at a level which will permit the center for Health Sciences to perform its educational functions without having to subsidize its service to the state—at an unfeasible level—through private practice, extramural research funds, and hospital charges to patients.

(4) Expanding the Center's program to produce increased numbers of health professionals.

(5) Improving communication between the Medical Center and the total University.

(6) Assembling a planning and management staff by the new chancellor for overseeing the development of the new health science complex at the western edge of the Madison campus.

(7) Establishing full-time associate deans of clinical sciences, basic sciences, and continuing education in addition to a dean.

(8) Appointing a Center for Health Sciences Board of Visitors to review program and operations.

(9) Committing the Center's resources to provide leadership throughout the State of Wisconsin in all aspects of health care.

continued on page 37A

Dr. Handy Named New State Health Chief

George H. Handy, MD, who has a background in both private general practice and public health service, in mid-January was named state health officer and administrator of the State Division of Health by the Wisconsin Health and Social Services Board. The appointment is expected to be confirmed by the State Council on Health at its meeting January 29.

Dr. Handy

Dr. Handy will succeed E. H. Jorris, MD, who is retiring February 1 after 34 years with the state's public health agency.

Dr. Handy began practicing general medicine in Wisconsin Rapids shortly after the end of World War II, remaining there until 1964 when he joined the state health division.

He was named assistant health officer in 1967, the same year in which he was appointed an assistant clinical professor at the University of Wisconsin Medical School.

Dr. Handy also has been director of the Bureau of Comprehensive Health Planning, a position that has required substantial contacts throughout the state with many health groups and governmental agencies.

GERALD C. KEMPTHORNE, MD (left) of Spring Green, representing the Sauk County Medical Society, in December presented a $500 check as the first contribution to a new student-organized fund to aid deserving students at the University of Wisconsin Medical School to Dean Peter L. Eichman, MD (center) in Madison. At right is Brian Kanter, Milwaukee, one of the medical student organizers of the program. Goal of the fund is to help more rural and inner city students enter the medical profession. Coordinating the program for the students is the Wisconsin Medical Alumni Association. The State Medical Society of Wisconsin also has a similar fund known as the George W. Hilliard, Jr., MD Fellowship Fund which is administered by the Society's Charitable, Educational and Scientific Foundation. The fund was established by the SMS Council in May 1969 following the death of Doctor Hilliard, a Negro physician who had devoted many hours to helping the minority and disadvantaged groups.

UW to Research Medical Costs–Services

A grant of $210,000 for basic research in medical costs and services has been given to the University of Wisconsin by the U.S. Department of Health, Education, and Welfare.

The grant will be used by the newly established Health Economics Research Center on the Madison campus.

Prof. Ralph L. Andreano, director of HERC, said the grant would support research being done by numerous professors, all in the economics field.

Among a wide range of studies scheduled will be: the definition and measurement of physician productivity, an analysis of the role of medical practice in delivering health care to the poor, a medical care cost index, and the effect of the use of ancillary personnel (nurses, technicians) on prices paid by the consumer.

In addition, Prof. Andreano said that one of the most important goals of the center would be a comparison of group versus solo medical practice.

"We're putting together modern economic research models for the medical sector, something that has been neglected for a long time," Prof. Andreano said.

The grant was provided by the HEW National Center for Health Services Research and Development.

TASK FORCE

continued from page 36A

(10) Creating and sustaining those programs which can take full advantage of the new developments in knowledge and technology as well as providing for the effective delivery of health care.

Members of the task force in addition to Prof. Shain include: James W. Nellen, MD, UW Regent from DePere; Philip P. Cohen, MD, chairman of physiological chemistry and former acting dean of the Medical School; Helen A. Dickie, MD, medicine; Charles C. Lobeck, MD, chairman of pediatrics; UW Vice President Donald E. Percy; Valencia N. Prock, RN, dean of the School of Nursing; Len Van Ess, UW–MSN assistant vice chancellor; and James W. Varnum, superintendent of University Hospitals.

Dr. Curran Reappointed

William P. Curran, MD of Antigo has been reappointed to the Council on Hospital Regulation and Approval, an agency of the State Division of Health. His term started Dec. 3, 1970 and continues to July 1, 1973. Dr. Curran is a past president of the State Medical Society.

Dr. Gilbert, La Crosse, Named to Advisory CHP Council

In late December Robert L. Gilbert, MD of La Crosse was appointed to the Advisory Comprehensive Health Planning Council by Gov. Warren P. Knowles.

Warning!

CHAMPUS I.D. Cards Stolen

All providers of service to CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) beneficiaries have been notified that a large number of CHAMPUS Identification Cards were stolen from Fort Sheridan, Ill., last December.

The cards can be identified as follows:

DD Form 2A (Retired)
10 16823 thru 10 17000
10 117003 thru 10 117015 (signed L. K. Johnson)
10 17016 thru 10 17 280

DD Form 2A (Active)
E5 80305 thru E5 80308 (signed L. K. Johnson)
E5 80313 thru E5 80326
E5 80351 thru E5 80664

DD Form 1173 (Dependent)
FK71,811A thru FK71,815A (signed L. K. Johnson)
FK71,821A thru FK71,850A (signed L. K. Johnson)
FK71,864A thru FK71,865
G119,191A thru G119,340A

DD Form 2 (Reserve)
SNO 95029 (about 500—ending number not known)

The CHAMPUS program in Wisconsin is administered by WPS Blue Shield whose offices have stated that if patients present identification cards with the above numbers, providers are to submit the claim, if one has been incurred, and all available patient identification to the WPS office as quickly as possible.

Providers have been warned that the cards will probably be used, if at all, by persons who are *not eligible* for CHAMPUS benefits.

SMS Hot Line

HEALTH AND MEDICAL LEGISLATION is flooding into the 80th session of the Wisconsin Legislature. A variety of bills has been introduced to liberalize the state's abortion laws, support family planning, and create alcoholism and drug treatment centers. The State Medical Society will introduce or support legislation to ease the medical manpower shortage, encourage expansion of enrollment at the state's two medical schools, provide financial assistance to students, and develop some kind of physician assistant training and regulatory program. In addition, the SMS will introduce legislation requiring safety glasses for students in high school agricultural and vocational training courses, a medical, advisory council to the Motor Vehicle Division, a laboratory licensing program, and passage (for the second time) of a bill to provide county or multiple county medical examiner systems to replace the coroner.

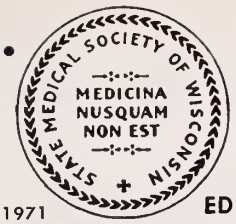
UNLICENSED FOREIGN GRADUATE PHYSICIANS ''who act as surgical assistants or helpers at the operating table directly aiding a licensed surgeon in surgical procedures are in violation of (state statutes) for practicing surgery without a license.'' This is the essence of an Attorney General's ruling to the Medical Examining Board. The ruling has been adopted as a regulation by the Board.

A LIST OF 359 DRUGS which ''lack substantial evidence of efficacy'' is being distributed to state and county medical societies with the request that the information be made available to all members of the profession. The Pharmaceutical Manufacturers Association at the same time says that two-thirds of the products on the list are already off the market some as long as 20 years ago. Of the 92 remaining on the market, PMA says there is considerable scientific debate about their effectiveness.

GOVERNOR LUCEY WAS WARNED of a major crisis in health manpower at a budget hearing called by the Governor at Stevens Point on December 22. Dr. Robert Callan, Milwaukee, immediate past president of SMS, said there was no ''instant solution'' for the doctor shortage, and called for rapid expansion of the enrollments of Wisconsin's two medical schools, greater financial support to the schools, and a variety of approaches to attract medical students and MDs to the state. Dr. Ben Lawton, Marshfield, chairman of the Society's Commission on Scientific Medicine, said the crisis will ''make pollution look like a Sunday school picnic.'' Dr. Dale Moen, Shell Lake, chairman of the Society's Commission on Hospital Relations and Medical Education, told the Governor that family medicine programs at both medical schools should be expanded to ease the shortage of rural physicians.

DISABILITY EVALUATION HANDBOOK is being sent to every physician by Dr. Henry A. Anderson, Stevens Point, chief medical consultant for Social Security disability insurance of the State Division of Vocational Rehabilitation. The book was prepared in cooperation with the Council on Medical Services of the AMA and is a useful guideline for evaluating disabled patients who are eligible for Social Security benefits.

SECTION



OPHTHALMOLOGY

JANUARY 1971

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

NEW DEPARTMENT AT U.W.

Matthew D. Davis, MD, has been appointed Professor of Ophthalmology and Chairman of the Department of Ophthalmology at the University of Wisconsin in Madison. Concurrently with Doctor Davis' appointment to the full-time faculty of the Medical School, ophthalmology was reorganized as an independent Department, having previously been a Division of the Department of Surgery.

Doctor Davis graduated from the University of Pennsylvania Medical School. His internship and residency in ophthalmology were at the University Hospitals in Madison. Following residency, Doctor Davis was granted a Heed Fellowship for study with Charles Schepens, MD, at the Retina Service of the Massachusetts Eye and Ear Infirmary in Boston. After returning to the University of Wisconsin in 1956, Doctor Davis played an active role in the ophthalmology training program, both at the medical student and resident levels. He has become well known for his clinical research in diabetic retinopathy and as a retinal detachment surgeon.

Doctor Davis hopes to maintain an active clinical practice in these fields while at the same time expanding the Ophthalmology Department in Madison, particularly in the area of research and postgraduate medical education.

Peter A. Duehr, MD, the preceding Chairman of Ophthalmology, will continue as an active part-time member of the Department as will all of the present part-time faculty members.

DR. KANNER JOINS CLINIC

Dr. Albert V. Kanner has joined the Davis and Duehr Eye Clinic in Madison. Dr. Kanner also will be associated with the Department of Ophthalmology at the University of Wisconsin Medical Center.

Dr. Kanner has been practicing in Madison since 1960 and was associated with Drs. Schubert and Aageson. Dr. Schubert died a few years ago and Dr. Kanner continued in solo practice after the death of Dr. Aageson a year ago.

NEW OPHTHALMOLOGIST IN GREEN BAY

Clarence L. Blahnik, MD recently joined MDs Oliver M. Hitch, John A. Ottum, and Reed C. Andrew in the practice of ophthalmology in Green Bay.

Dr. Blahnik graduated from Marquette University School of Medicine (now called The Medical College of Wisconsin) and interned at Queen of Angels Hospital, Los Angeles, Calif. He took a one-year general practice residency at LaFayette Charity Hospital in LaFayette, La. Prior to his ophthalmology residency he was in general practice in Peshtigo.

Dr. Blahnik completed his ophthalmology residency at Charity Hospital, New Orleans, La., under the Louisiana State University School of Medicine service. In addition to his residency he took a one-year Retinal Fellowship under Dr. Edward Okin at McMillan Hospital, St. Louis, Mo.

UW EXHIBIT WINS AWARD

During the seventy-fifth annual session of the American Academy of Ophthalmology and Otolaryngology, Oct. 5–9, 1970, in Las Vegas, Nev., the third place award was given to the scientific exhibit on "Cytomegalovirus Retinitis in Adults After Renal Homograft." The exhibit was presented by Guillermo de Venecia, MD, Mary V. Pratt, MD, and Miss Marlene Wahlstrom of the Department of Ophthalmology and Gabriele ZuRhein, MD of the Department of Pathology of the University of Wisconsin Medical Center, Madison.

ARE YOU INTERESTED IN MEDICAL HISTORY?

The Academy of Medical History (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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NEWS HIGHLIGHTS

State Dermatologists Elect Officers

The Wisconsin Dermatological Society met November 14 in Madison at University Hospitals for election of officers, a scientific program, and social dinner.

New officers are: president, William F. Schorr, MD,* Marshfield; vice-president, Robert R. Baumann, MD,* Monroe; secretary-treasurer, Hubert V. Moss, MD,* Madison.

The program consisted of presentation of 21 clinical cases. There were 43 dermatologists in attendance. The 1971 program also was planned with a February meeting in Milwaukee and an April meeting in Marshfield.

The Section on Dermatology of the State Medical Society of Wisconsin also met and elected Dr. Schorr as its chairman. Joel E. Taxman, MD* of Milwaukee is the delegate and Garrett A. Cooper, MD* of Madison is the alternate delegate to the SMS.

Following the meeting a reception was held at the home of Sture A. M. Johnson, MD,* professor and chairman of the department of dermatology at the University of Wisconsin Medical Center. The group then went to the Maple Bluff Country Club for dinner.

Guests of the society were the attending dermatologists' wives and the dermatology residency staffs from The Medical College of Wisconsin and the University of Wisconsin Medical School.

Milwaukee Physicians' Guild Elects Officers

John E. Sinsky, MD,* a Wauwatosa obstetrician, was elected president-elect of the Catholic Physicians' Guild of Milwaukee at the organization's annual meeting held at Trinity Hospital in Cudahy on Dec. 6.

Dr. Sinsky will assume the office of president in December 1971 succeeding John A. Kelble, MD,* a Fox Point anesthesiologist. Dr. Kelble was installed as president for the forthcoming year.

Nicholas Damiano, MD,* a general practitioner of Hales Corners, was elected to a two-year term as secretary–treasurer.

Paul J. Lawler, MD,* a Wauwatosa psychiatrist, was reelected to a three-year term as a member of the Board of Directors. Hold-over members of the Board are James V. Pilliod, MD,* Wauwatosa internist, and Thomas C. Lipscomb, MD,* Wauwatosa radiologist.

State Orthopedic Surgeons Meet

Some 50 members of the Wisconsin Orthopedic Society met October 30 in Beloit with MDs William M. Hebble* and Allen O. Tuftee* as hosts.

Resident surgeons from Milwaukee and Madison presented papers. Society members also presented problem cases.

A Mayo Clinic physician, Leon Peterson, MD, was the guest dinner speaker. His subject was "On the Total Hip Replacement."

The following officers were elected for two-year terms: president—Sion C. Rogers, MD,* Madison; vice-president—Paul W. Phillips, MD,* La Crosse; secretary-treasurer—James M. Huffer, MD,* Madison; delegate—Paul A. Jacobs, MD,* Milwaukee; and alternate delegate—Peter B. Golden, MD,* Madison.

Ozaukee Society Elects Officers at Mequon

The December 10 meeting of the Ozaukee County Medical Society was held in Mequon with election of officers as follows: president—Arnold H. Barr, MD* of Port Washington; vice-president—Philip W. Wallestad, MD* of Port Washington; and secretary–treasurer—John F. Walsh, MD* of Port Washington. Dr. Wallestad and Robert H. Dorr, MD* of Belgium will serve two-year terms as delegate and alternate delegate, respectively.

PHYSICIAN BRIEFS

G. Stanley Custer, MD*

. . . a Marshfield Clinic physician, in association with other medical men from around the nation, has been named a consultant to develop a new medical school at Texas Technological University at Lubbock, Tex. The new school will be developed around the group medical practice concept. Dr. Custer is president of the State Medical Examining Board, president of the American Association of Medical Clinics, and a member of the Public Health Service National Advisory Health Council.

Alphons E. Bachhuber, MD*

. . . a Kaukauna physician for 38 years, retired the first of January.

Thomas L. Carter, MD*

. . . Madison, has been named by the Wisconsin Radiological Society as public relations representative to the American College of Radiology. In this position he is available to answer all questions about radiology, radiologists, or radiation, either technical or non-technical.

Russell H. Owen, MD*

. . . Monroe, recently became associated with the medical staff of St. Clare Hospital. Doctor Owen is a graduate of the University of Wisconsin Medical School and completed his residency in anesthesiology at University Hospitals in Madison. He joins J. Alexander Villacrez, MD*, who is already with the department of anesthesiology at the hospital.

William A. Sannes, MD*

. . . Soldiers Grove, recently was honored by the Soldiers Grove community at the annual All Breeds dinner. Doctor Sannes has spent 37 years in serving the community and received the plaque of appreciation from the people of Crawford County.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Milwaukee Cancer Division Awards Grants of $13,560

Four cancer research grants totaling $13,560 were awarded to Milwaukee scientists by the Milwaukee Division of the American Cancer Society, according to an announcement by Edward G. Ricker, Jr., division president. All are members of the Medical College of Wisconsin.

Mr. Ricker pointed out that the grants were approved by the cancer society's medical and scientific committee and are made possible through the community's continued support of the annual Cancer Crusade.

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Dr. Ramirez is Speaker for Madison Ob–Gyn MDs

The Madison Obstetrics and Gynecology Society will have as their guest lecturer, February 2, Guillermo Ramirez, MD,* assistant professor of oncology at the University of Wisconsin Medical Center, who will discuss "Chemotherapy of Gynecology Malignancy." The dinner meeting will start at 6:30 p.m. at the Cuba Club in Madison.

The Society's November 3 meeting was also held at the Cuba Club with Adolf Stafl, MD,* assistant professor of gynecology at The Medical College of Wisconsin, speaking on colposcopy.

Other physicians wishing to attend the February meeting may do so by contacting the president, Gordon L. Eckert, MD,* or the program chairman, Luis B. Curet, MD.*

UW Med Center Scientists Receive Cancer Grants

The University of Wisconsin Medical Center and a number of its foremost cancer scientists have again been recipients of grants from the American Cancer Society.

Among those receiving individual grants or fellowships, in addition to an $18,333 institutional grant received by the University for a three month's extension of its existing grant, is Henry C. Pitot, MD* who was granted $36,025.

A total of $241,864 in grants has been made so far this fiscal year. An additional amount will be realized before June 1971.

Milwaukee Drops Health Screening Program

Milwaukee's multiphasic health screening program ended its services on Dec. 23, 1970. The program, which has offered free health examinations to more than 25,000 since 1967, was dropped because of the discontinuation of funds from the US Public Health Service.

E. R. Krumbiegel, MD,* city health commissioner, had sought city funds to continue the program without federal help, but the Common Council approved an amendment to the 1971 budget, eliminating positions related to the multiphasic program.

Dr. Twelmeyer Heads Milwaukee Society

Henry F. Twelmeyer, MD,* was elected president of The Medical Society of Milwaukee County at its annual meeting December 10. Dr. Twelmeyer assumed office on January 1, when retiring president, Robert B. Pittelkow, MD,* became a director of the medical society.

David J. Carlson, MD,* was elected for the office of president-elect, Robert S. Pavlic, MD,* was elected to the office of secretary-treasurer, and Thomas F. Jennings, MD,* was elected interim director at large.

Other members of the Board of Directors included Eugene G. Collins, MD;* Christopher R. Dix, MD;* George E. Collentine, MD;* Howard L. Correll, MD;* Daniel K. Schmidt, MD.*

Dr. Twelmeyer is a native Milwaukean and was born April 19, 1919. He was graduated magna cum laude from Marquette University with a bachelor of science degree, and in 1942 received his medical degree from Marquette University School of Medicine.

After completing his internship at Milwaukee County General Hospital, Dr. Twelmeyer spent three years in the United States Army Medical Corps during World War II. He returned to Milwaukee County General Hospital in 1946 and completed residency training in surgery in 1950. He was granted an MS degree in surgery.

Dr. Twelmeyer was a pioneer in the field of cardiovascular surgery in Milwaukee in the early 1950s. Today, Dr. Twelmeyer is an assistant clinical professor of surgery at the Medical College of Wisconsin. He has served as chief of surgery at West Allis Memorial Hospital and Elmbrook Memorial Hospital and is presently engaged in the practice of general and vascular surgery.

Dr. Twelmeyer is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons. He is immediate past president of the Milwaukee Academy of Surgery and a past member of the Council of the Wisconsin Surgical Society. In addition to his medical society memberships, Dr. Twelmeyer is a member of the Wisconsin Heart Association and the Milwaukee Academy of Medicine. He is on the active staffs of Elmbrook Memorial, St. Francis, St. Luke's and West Allis Memorial hospitals.

Dr. Twelmeyer has held numerous positions in the county medical society. He also became the State Medical Society's new alternate delegate to the American Medical Association the first of January.

Dr. Twelmeyer

Dr. Pittelkow

Dr. Carlson

Dr. Melby

Dr. Carlson is a graduate of the Marquette University School of Medicine and was licensed in 1944. He is certified in pathology and received his internship and residency training at Youngstown Hospital Association of Youngstown, Ohio, and at St. Mary's Hospital from 1947 to 1949 and at St. Joseph's Hospital from 1949 to 1950.

Dr. Carlson is director of the pathology laboratory for St. Mary's Hospital and is an assistant clinical professor of pathology at the Medical College of Wisconsin and is a member of the International Academy of Pathology, the American Association for the Advancement of Science, the American Association of Blood Banks, Society for Nuclear Medicine, the College of American Pathologists, Wisconsin Society for Pathologists, and the Milwaukee Academy of Medicine.

Neal A. Melby, MD*
Martin L. Janssen, MD*

. . . New Richmond and Friendship, respectively, were recently selected for inclusion in the 1970 edition of "Outstanding Young Men of America." Doctor Melby graduated from the University of Wisconsin Medical School in 1965. He is associated with A. H. Armstrong, MD,* J. L. Craig, MD,* and L. W. Weisbrod, MD* in the New Richmond Clinic. Doctor Janssen also is a graduate of the UW Medical School. In 1960 he became associated with Arthur Weihe, MD* in the Roche-a-Cri Clinic in the Adams–Friendship area. In 1969 he was appointed the Adams County coroner by Gov. Warren Knowles.

Dr. Janssen
(Dr. Melby's picture appears at the left)

Karl P. Ruppenthal, MD*

. . . has retired from practice after serving the Bangor community for 42 years.

Albert C. Schmidt, MD*

. . . Milwaukee, recently was honored at a scientific program and dinner by the Milwaukee Orthopaedic Residents Alumni Club. Doctor Schmidt, with Walter Blount, MD*, and the late Herman Schumm, MD, founded the training program in orthopedic surgery at Milwaukee Children's Hospital in 1946. Doctor Schmidt is a clinical professor of orthopedic surgery at the Medical College of Wisconsin and has been an examiner for the American Board of Orthopaedic Surgery for 20 years. He also is chairman of the orthopedics department at Columbia Hospital.

Jesus Sierra, MD

. . . La Crosse, has joined the medical staff of the La Crosse Clinic, Ltd., and St. Francis Hospital. Doctor Sierra, a native of Barranquilla, Colombia, graduated from the National University of Mexico City Medical School and completed his internship at Juarez Hospital, Mexico City, Mexico. He served two years of general surgery and three years of orthopedic surgery at Baroness Erlanger Hospital, Chattanooga, Tenn. Doctor Sierra also attended a course in lower extremity prosthetic and orthotics at New York University.

Walter F. Lappley, MD*

. . . Cross Plains, recently was honored at an appreciation dinner for his long time services to the community and surrounding areas. Doctor Lappley graduated from the University of Wisconsin Medical School in 1934 and interned at St. Mary's Hospital, Madison. He spent the next five years with the State Department of Public Welfare. During World War II, he served as a captain in the 95th Evacuation Hospital with the 5th Army in North Africa and Italy. He has often stated that he is proudest of the title "general practitioner" and was never too busy to make house calls no matter what the time or distance.

Sanford Mackman, MD*

. . . Madison, recently was featured in "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Mackman, who graduated from the University of Wisconsin Medical School in 1959, has been associated with the University as a physician, surgeon, and teacher. In his eleven years at the University, Doctor Mackman has received three distinguished teaching awards and an American Cancer Society advanced clinical fellowship for three years. He is leaving his post at the University and will become affiliated with the Jackson Clinic in Madison.

James H. Brandenburg, MD*

. . . Madison, recently was the guest speaker at the Winnebago County Medical Society. His topic was entitled "Cancer of the Head and Neck."

Winnebago County Physicians Respond to Nader's Report

In response to a report by a special Ralph Nader investigative team, the Winnebago County Medical Society stated that medical societies probably police their members harder than any other profession.

The report by the Nader team, composed of medical students and law students, said that the medical profession is not protecting the public from incompetent doctors. It called for a presidential board to set up quality control standards for doctors. "The almost complete lack of internal quality controls in the medical profession has allowed a large measure of very poor medicine to be practiced," the team said.

As reported in the APPLETON POST-CRESCENT reaction among Winnebago County physicians has been a loud "not so." The report, they claim, ignores the system of professional self-scrutiny—known as peer review—which has expanded greatly in the area's hospitals during the past decade.

The Nader report, "One physician —One Life," criticized doctors for failing to keep up with changes in medicine. "Even if (a physician) receiving his license in 1930 and has earned nothing since, he is free to practice almost totally unimbided by law," the report said. The medical society said that such a statement totally ignores the standards established by hospital staffs in Winnebago County to control the quality of medical practice and to keep it up to date.

DATO Ward Opens at Wyocena Hospital

A special section for psychiatric patients at the Columbia County Hospital and Home at Wyocena recently was completed. Its technical name is "Direct Admissions Treatment Option" (DATO).

Built with $90,000 surplus from out-of-county patient refunds, the new space permits admission of county patients who would otherwise have to go to state mental hospitals.

Staffed by Ralph D. Froelich, MD* and Fred H. Koenecke, Jr., MD,* Madison, the physicians will be in attendance on Mondays and Fridays, and daily on a telephone consultative basis.

With the creation of the DATO unit, the Cushman Manor, Columbia Hospital, and Cushman Home are joined in a two-block complex.

Marshfield Clinic Opens New Neurology–Psychiatry Center

The Marshfield Clinic recently opened a new neurology and psychiatry center. The center staff includes six neurologists, five psychiatrists, two neurosurgeons, four psychologist and five psychiatric social workers.

AMA Officer Talks to County Societies

About 100 persons were present December 9 at Monroe to hear the assistant and executive vice-president of the American Medical Association talk on "Medical Practice in the 70's."

Richard S. Wilbur, MD of Chicago presented problems to be faced by the doctors and their patients under national health insurance coverage, prepaid medical care, and medical foundations, all vital issues of the 1970s.

Among guests were Earl Thayer, newly-elected secretary of the State Medical Society, and officers of the Lafayette and Rock county medical societies and their wives.

John M. Irvin, MD* of Monroe is president of the Green society.

Psychiatric Residency Program Approved

Recent accreditation by the Joint Commission on Accreditation of Hospitals of Winnebago State Hospital includes approval of a new three-year residency program in psychiatry.

George Lysloff, MD, training and research director at the hospital, said that the new program rounds out the hospital's training function in the community.

Med–Col of Wisconsin Has Largest Freshman Class in School's History

The freshman class of the Medical College of Wisconsin is the largest in the history of the school (formerly Marquette School of Medicine), according to a recent announcement by the school.

The class also has more women students than any previous first-year class. Eleven of the 111 freshmen are women. The class includes two black Americans, one from Milwaukee and one from Mississippi. This year's freshman enrollment is up five from last year's total of 106.

The students represent a wide spectrum of undergraduate backgrounds. They come from 49 undergraduate schools and 27 of them graduated with honors or such designations as magna and summa cum laude, cum laude or with distinction. Nine of the freshmen have advanced degrees, including one PhD and one doctor of veterinary science. While science majors still account for the greatest number, a few freshmen also come from such fields as economics, engineering, Hebrew, Italian, history, mathematics, and philosophy.

Their homes are in 15 states and two foreign countries. The largest number (43) are from Wisconsin. Second and third states in representation are California (21) and New York (15). The foreign students are from Korea and Hong Kong.

This year's freshman class was culled from a total of 2,530 applications, 238 of them from Wisconsin residents. Although most of the students were interviewed in Milwaukee, some regional interviews were held on the West and Northeast Coasts and in the state of Hawaii. Those accepted have an overall grade point of 3.21, with an average grade of 3.24 in science courses.

Attend Prepaid Plans Conference

MDs Robert Krohn* of Black River Falls and Howard Mauthe* of Fond du Lac attended the Western Conference of Prepaid Plans held the first week in November in Victoria, British Columbia, Canada. Both are members of the State Medical Society's Commission on Medical Care Plans.

Dr. G. R. Barry Given Internist Award

Addis C. Costello, MD,* Milwaukee (center), newly installed president of the Wisconsin Society of Internal Medicine, made, as his first official act, the presentation of a plaque award to the outgoing president, George R. Barry, MD,* Monroe (left), in recognition of Dr. Barry's achievements while president. Watching the action is Otto C. Page, MD, Portland, Oregon, president-elect of the American Society of Internal Medicine. Dr. Page spoke during the Society's annual business session held in September. Over 100 physicians from throughout Wisconsin attended two days of scientific sessions sponsored jointly by the Wisconsin Society of Internal Medicine and the American College of Physicians.

Stan W. Boyer, MD

. . . Madison, has joined the Jackson Clinic in the department of neurology and electroencephalography. A native of Indiana, Dr. Boyer graduated from Indiana University School of Medicine in 1962. He served his internship at the Charles T. Miller Hospital in St. Paul, Minn., and spent the following three years as a medical officer with the U. S. Public Health Service in Cass Lake, Minn., caring for the residents of the Leech Lake Indian Reservation. Prior to coming here, Dr. Boyer served a four and one-half year fellowship at the Mayo Clinic, Rochester, Minn. He spent three and a half years as a fellow in neurology and an additional year in electroencephalography.

Dr. Boyer

Dr. Hirsch

Erwin O. Hirsch, MD

. . . director of medical education at the Princeton (N. J.) Hospital, has been appointed associate dean for student affairs at The Medical College of Wisconsin, Milwaukee. The Boston-trained internist also has been appointed associate professor in the medical college's Division of Medicine, where he will have some teaching responsibilities in hematology. He is best known for his investigative work on the transfusion of human blood platelets.

Joseph C. Darin, MD*

. . . director of surgery at Milwaukee County General Hospital and professor and acting chairman at the Medical College of Wisconsin, participated in a roundtable discussion on "Diagnosing the Causes of Nausea and Vomiting," held October 23–24 in Mexico City. Dr. Darin was one of a group of physicians from the United States and Mexico who contributed to this roundtable discussion. Their comments will serve the basis for a coming feature article in PATIENT CARE.

Leo G. Joseph, MD*

. . . La Crosse city health officer since 1966, recently resigned his position to return to private practice. Doctor Joseph was associated with F. W. Ernst, MD* in 1957 and later became associated with Frank Gallagher, MD* and John Simones, MD* before his appointment as city health officer.

Frank C. Iber, MD*

. . . and his wife, Betty, of Springville have written another novel entitled "The Egomaniac." The authors have used their middle names, Christian Iber, MD and Jane Iber, on the title page. Publisher is Exposition Press of Jericho, N.Y. This is the Iber's fourth novel.

J. R. Salan, MD*

. . . Waupaca, recently was chosen chief of the medical staff at Riverside Community Memorial Hospital. L. P. Maasch, MD,* Weyauwega, and J. H. Steiner, MD,* Waupaca, are vice-president and secretary–treasurer, respectively. Doctor Salan succeeds M. O. Boudry, MD* of Waupaca.

Remodeled Emergency Rooms at University Hospitals to Aid Area Health Care

Newly remodeled emergency room facilities at University Hospitals in Madison officially opened Dec. 17, 1970, after they had been shown to fire rescue, police, sheriff, and other Madison and neighboring community officials the previous day.

Included in the modernization are a covered ambulance receiving area with automatic doors, two completely equipped trauma rooms, x-ray facilities, three examining rooms, a cast room, a nursing station and a waiting area. The $150,000 project began last summer and continued while cases were treated in an adjacent area.

The new facilities, which are virtually a self-contained department, are designed for the treatment of multi-system trauma cases such as auto crashes, industrial accidents and farm mishaps, as well as medical cases such as heart attacks, says Louis C. Bernhardt, MD, director of emergency room services at University Hospitals.

Said University Hospitals Superintendent James W. Varnum, "We feel that this remodeling of emergency facilities is an excellent way to prove our desire to participate in Madison and southcentral Wisconsin's everyday health care problems."

The remodeling is the first step in long range plans to obtain a regional trauma center at University Hospitals, according to Dr. Bernhardt, who also is an assistant professor of surgery, and along with Charles J. Johnson, MD,* assistant professor of surgery, chairs the department's ER committee.

University Hospitals' emergency room facilities had a total of 13,355 visits during the past year.

Alcohol Remains Major Menace for Drivers

A recent report by the Wisconsin Division of Health indicates that blood alcohol tests taken on 380 of the drivers killed in motor vehicle accidents on Wisconsin streets and highways during the 10 months of 1970 indicate that 234, or 62%, had some alcohol in the blood, and 141, or 37%, were at or above the 0.15% blood alcohol level—the presumptive level of intoxication under State law.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

January 1, 1971—June 30, 1971

STATE DEPARTMENT OF PUBLIC INSTRUCTION

BUREAU FOR HANDICAPPED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*	*Location*	*Date*
Manitowoc	February 17 and 18	Rhinelander	April 28 and 29
Stevens Point	March 17	Sheboygan	May 5 and 6
Racine	March 3 and 4	Chippewa Falls	May 18 and 19
Ashland	March 25 and 26	Superior	May 25
Kenosha	March 31 and April 1	Lancaster	June 9
Eau Claire	April 21 and 22	Darlington	June 10
La Crosse	April 14 and 15		

FOR: Clinics conducted by the Crippled Children Division of the Bureau for Handicapped Children are for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are sent to the referring physician following clinic.

REFERRAL FORMS: Referral forms may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

ADDRESS CORRESPONDENCE: Bureau for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.

Donald R. Kahn, MD

. . . a University of Michigan surgeon, will be joining the University of Wisconsin Medical School faculty soon, according to an announcement by Dean Peter L. Eichman, MD.* He will join the faculty as professor and chief of the division of chest and heart surgery. Dr. Kahn has performed several heart transplant operations. His reason in coming to Wisconsin, he said, is the opportunity to head his own surgical division and "the tremendous potential for cardiovascular surgery" here.

William B. Parsons, Jr., MD*

. . . Madison, recently was named chairman of the Dane County Unit of the Wisconsin Heart Association. Doctor Parsons succeeds John H. Morledge, MD*, who has been chairman for the past two years. □

CONTRIBUTIONS—CES FOUNDATION
November 1970

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for November 1970:

Nonrestricted

Anonymous	Contribution
State Medical Society Members	Voluntary contributions of 3 MDs
Dr. & Mrs. E. J. Nordby	Memorial: Nels C. Lerdahl
Dane County Medical Society	Memorial: Madeline J. Thornton, MD
Wisconsin Physicians Service	Memorial: Charles Hayden, MD, President of Massachusetts Blue Shield
Margaret K. Pharo, Earl R. Thayer, R. L. Minshall, Mr. & Mrs. Ralph Anderson	Memorial: Albert Nelson
Mr. & Mrs. Ralph Anderson	Memorial: John Ryan
Mr. & Mrs. Ralph Anderson and Margaret K. Pharo	Memorial: Andrew Schaffer
Dr. & Mrs. O. N. Arneson	Memorial: Wayne R. Shepard
State Medical Society	Memorials: G. O. Shaner, MD; F. G. Bachhuber, MD; M. J. Thornton, MD; R. H. Wink, MD; Frank Balistreri, MD; and A. J. Macht, MD

Student Loans

State Medical Society Members	Voluntary contribution of 1 MD

Charitable–Disabled Physicians

State Medical Society Members	Voluntary contribution of 1 MD

Other Than CESF Projects

State Medical Society Members	Voluntary contribution of 1 MD

J. G. Crownhart Memorial Fund

C. H. Crownhart	Memorials: Robert H. Broker and Mrs. Frank Pyre

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Tormey Memorial Fund

Mr. & Mrs. J. G. Werner	Memorial: Neil Conway

Danforth Memorial Student Loan Fund

Mrs. Quincy H. Danforth	Contribution

High School Student Health Career Scholarship Fund

Julius M. Meyer, MD	Contribution
Howard L. Correll, MD	Contribution

Barbara Scott Maroney Memorial Fund for Research on Diabetes

Mr. & Mrs. Robert McKillop	Memorial: Barbara Scott Maroney

Cancer Exhibit

American Cancer Society	Contribution

□

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF DECEMBER 1970

1 Institute on Drug Use and Abuse for Nurses, State Division of Health
1 Madison General Hospital Surgical Staff
1 Madison Urological Society
1 Madison Anesthesiology Society
1 Dane County Medical Society Board of Trustees
2 American Board of Surgery Exams
3 Regional Advisory Group and Staff, Wisconsin Regional Medical Program
3 SMS Commission on Hospital Relations and Medical Education
4 State Medical Examining Board
9 Site Visit, Wisconsin Regional Medical Program
10 Board of Directors, Wisconsin Association of Professions
12 SMS Commission on Medical Care Plans
13 Executive Committee of SMS Council
14 Dane County Medical Society Insurance Advisory Committee
17 SMS Committee on Occupational Health

Meetings not he'd in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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OBITUARIES

George O. Shaner, MD, 64, Milwaukee, died May 28, 1970, in Milwaukee.

Born on Sept. 26, 1905, in Kewanee, Ill., Doctor Shaner graduated from the University of Nebraska Medical School in 1934 and served his internship and residency at Columbia Hospital, Milwaukee. He was a fellow of the American College of Surgeons and at one time served in the medical capacity at Cutler–Hammer, Inc., in Milwaukee.

Surviving are his widow and four children.

Francis Gregory Bachhuber, MD, 65, Mayville physician for 40 years, died Aug. 17, 1970, in Mayville.

Born on April 5, 1905, in Mayville, Doctor Bachhuber graduated from Northwestern University Medical School in 1930 and served his internship at Milwaukee County General Hospital before joining his father, the late Dr. Alphonse E. Bachhuber, in practice.

Doctor Bachhuber belonged to the medical staffs of St. Agnes, St. Joseph, Lutheran Deaconess and Waupun Memorial hospitals. He was a member of the Wisconsin Anti-Tuberculosis Association and was a medical examiner for New England Mutual and New York Life Insurance companies.

He was a member of the Dodge County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Lillian; three sons, Dr. Michael, Mayville; James, Santa Clara, Calif.; Fred, Warrensburg, Mo.; and three daughters, Mrs. Robert (Judith) Andresen, Franklin; Mrs. Gordon (Kathryn) Terry, Brookfield; and Mrs. Thomas (Marie Louise) Swittel, Wauwatosa.

Reuben Wink, MD, 67, Marshfield, died Sept. 21, 1970, in Marshfield.

Born on Oct. 12, 1902, he graduated from the Marquette University School of Medicine in 1926 and set up practice in Granton until 1941 when he opened a practice in Marshfield until his retirement in 1969. He was on the medical staff of St. Joseph's Hospital, Marshfield, and was a member of Wisconsin Academy of General Practice.

He was also a member of the Wood County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two sons, James, Milwaukee, and Donald, Marshfield; and a daughter, Mrs. Carol Beseler, Marshfield.

George Stanley Metcalf, MD, 76, Lewiston, Idaho, former chief of staff of Mercy Hospital, Janesville, died Sept. 27, 1970, in Lewiston.

Born on Oct. 15, 1893 in Janesville, Doctor Metcalf graduated from the University of Illinois Medical School in 1920 and served his internship at Milwaukee Hospital. Doctor Metcalf had offices in Janesville from 1920 until his retirement in 1963.

He was a former member of the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Doris; one son, Robert L., of Lodi; and a daughter, Mrs. Robert Colborn, Lewiston, Idaho.

Arthur J. Macht, MD, 57, Marshfield, died Oct. 6, 1970, in Marshfield.

Born on May 2, 1913, in Milwaukee, Doctor Macht graduated from the Marquette University School of Medicine in 1938 and served his internship at St. Joseph's Hospital in Milwaukee. After his two-year residency in psychiatry at Winnebago State Hospital, Doctor Macht became an instructor at the University of Wisconsin. In 1941, he became assistant clinical director of St. Mary's Hill Psychiatric Hospital, Milwaukee, where he remained until his association with Veterans Administration Hospital at Wood in 1949–1953. During his tenure at St. Mary's, he was a captain in the Army Medical Corps and served aboard the Army Hospital Ship Emily H. Weder, which operated in the Southwest Pacific. Doctor Macht joined the medical staff of the Marshfield Clinic in 1953.

He was a fellow of the American Psychiatric Association, and member of Wood County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Gertrude; six sons, Phillip, Wisconsin Rapids; Jeffrey and Joseph, Milwaukee; Tom, a student at the University of Wisconsin, Madison; and Mark and Erick, at home; and five daughters, Arlene, Chicago; Gretchen, Madison; Susan, a student at Wisconsin State University–Stevens Point; and Mary and Hannah, Marshfield.

Frank Balistreri, MD, 49, Glendale, died Oct. 7, 1970, in Milwaukee.

Born on June 25, 1921, in Sicily, Doctor Balistreri graduated from the New York University School of Medicine in 1948. He joined the staff of St. Joseph's Hospital in Milwaukee where he served his internship and residency. Doctor Balistreri served in the United States Navy for three years before being called into active duty as a doctor in the Army during the Korean conflict in 1953. He spent 10 years in general practice before his residency in physical therapy at the Veterans Administration Hospital at Wood, Wis. Doctor Balistreri was chief of the Physical Medicine and Rehabilitation Department at St. Michael Hospital in Milwaukee at the time of his death.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, American Congress of Rehabilitation, Wisconsin Society of Physical Medicine and Rehabilitation, and International Society of Physical Medicine and Rehabilitation.

Surviving are his widow, Phyllis; three sons, Michael, James and Steven; and two daughters, Gina and Aimee; all at home.

Madeline J. Thornton, MD, 69, prominent Madison obstetrician and gynecologist, died Oct. 8, 1970, in Madison.

Born on Mar. 29, 1901, in Schenectady, New York, Doctor Thornton graduated from Johns Hopkins Medical School in 1927 and served her internship there until 1929. She did her residency at University Hospitals, Madison, from 1929–1931, and was one of few women doctors ever to be on the staff, and also one of few to be in a surgical branch of medicine.

Doctor Thornton was an associate professor of obstetrics and gynecology and a lecturer in the home economics school at the University of Wisconsin besides doing her clinical duties. She also was director of the Family Service Society of Madison.

Doctor Thornton was a fellow of the American College of Surgeons, a diplomate of the American Board of Obstetrics and Gynecology, a member of the Central Association of Obstetricians and the International Association of Gynecologists, a member of the New York Academy of Science and the Wisconsin Society of Obstetrics and Gynecology. She was noted for her research in the fields of oral contraception and internal sanitary protection for women.

She was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are a sister, Mrs. E. S. Gillette, Lake Forest, Ill., and a brother, Cmdr. J. T. Thornton, Oquossoc, Me.

Frederick D. Geist, MD, 75, Madison, died Oct. 18, 1970, in Madison.

Born on Sept. 18, 1895, in Pittsburgh, Pa., Doctor Geist graduated from Tufts College Medical School in Boston in 1920. He had been on the faculty of the University of Wisconsin Medical School as an instructor, until his retirement in 1961. In 1966, he received the Emeritus Faculty Award of the University of Wisconsin Medical School Alumni Association for his devoted, stimulating teaching of human anatomy, the longest period of service in the department since the school was established in 1907.

He served in the United States Army in World War II with the 48th Surgical Hospital Army Unit in North Africa.

Surviving are his widow; and two sons, Frederick S. Geist, MD, Dallas, Tex., and Howard J. Geist, MD of Portland, Ore.

André Hunt Lamal, MD, 61, Ashland physician and surgeon for 35 years, died Oct. 31, 1970, in Ashland.

Born on Jan. 22, 1909, in Ashland, Doctor Lamal graduated from the Marquette University School of Medicine in 1934 and completed his residency in surgery at the Milwaukee County General Hospital.

With encouragement of W. J. Tucker, MD, Doctor Lamal returned to Ashland to practice in association with Doctor Tucker. In 1938 Doctor Lamal and his wife, the former Isabel Conway of Milwaukee, spent four months in Scotland where the doctor studied at the University of Edinburgh College of Surgery. Because of the development of World War II, the couple cut short their European tour and returned to Ashland where Doctor Lamal resumed his practice.

He was a member of the Ashland–Bayfield–Iron County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Isabel; five sons, Peter, Charlotte, N.C.; James, Algoma; André Jr. and Jonathan, Berkeley, Calif.; Christopher, Washington, D.C.; and three daughters, Mrs. Isabel Plater, Reno, Nev.; Mrs. Mary Ostrom, Rochester, Minn.; and Suzanne, Madison. Four other children preceded him in death.

Harry W. Sargeant, MD, 83, Hubertus, died Nov. 9, 1970, in Menomonee Falls.

Born on Jan. 28, 1887, in Long Prairie, Minn., Doctor Sargeant graduated from the Marquette University School of Medicine in 1914 and served his internship at Milwaukee County General hospital. He served in the United States Army Medical Corps during World War I, after which he returned to Milwaukee and became house surgeon for residency training. In 1920, Doctor Sargeant became acting superintendent of Milwaukee County General Hospital and in 1922 was appointed administrator of the hospital until 1957. After his retirement in 1957, he became the administrator at the Long Prairie Memorial Hospital in Minnesota until 1968.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Katherine; a son, Dr. Thomas, Janesville; and a daughter, Mrs. Don Zentner, Wauwatosa.

Sarah D. Rosekrans, MD, 69, Neillsville physician for over 40 years, died Nov. 15, 1970, in Rochester, Minn.

Born on July 10, 1901, in Hartfield, Conn., she graduated from the University of Minnesota Medical School in 1928 and served her internship at Fairview Hospital. Doctor Rosekrans worked with her husband as one of the few husband and wife doctor teams in the state. In 1947, she attended the organizational meeting in Mexico of the Pan American Medical Women's Alliance serving as president-elect from 1956–58 and president from 1958–60.

She was a founder and the president of the Neillsville Business and Professional Women's Club in 1940 and in 1942 became a director of the state federation. She also was a member of the World Medical Association, the Wisconsin Society of Obstetrics and Gynecology, American Academy of General Practice, the American Medical Women's Society, and was listed in "Outstanding American Women," "Women of the Northwest," and "Who's Who."

Doctor Rosekrans was a delegate to world medical conventions in Cuba, Turkey, and Finland and for several years was chief of the medical staff at the Neillsville Memorial Hospital.

She was past president and a member of the Clark County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are her husband, Dr. Milton C. Rosekrans, Neillsville; and two daughters, Mrs. Elizabeth Hagen, Minneapolis, Minn., and Mrs. Howard Stanley, Half Day, Ill.

Jerome A. Pizer, MD, 46, Oak Creek health commissioner, died Nov. 18, 1970, in an airplane crash in the town of Weston near Wausau. His wife, Irene, also was killed in the crash.

Born on Sept. 12, 1924, in Milwaukee, Doctor Pizer graduated from the University of Wisconsin Medical School in 1952 and interned at Letterman Army Hospital in San Francisco, Calif. He served in the United States Army during World War II and saw action in the Philippines and on Okinawa. Doctor Pizer had been a member of the Trinity Memorial Hospital, Cudahy, since its opening in 1958.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two children, Pamela and Andrew of Milwaukee.

Robert A. Rufflo, MD, 40, Milwaukee, died Nov. 18, 1970, in an airplane crash in the town of Weston near Wausau. His wife, Beatrice, also was killed in the crash.

Born on Jan. 2, 1930, in Milwaukee, Doctor Rufflo graduated from Marquette University School of Medicine in 1954 and interned at Rochester General Hospital in Rochester, N.Y. His residency was served at Akron City Hospital, Akron, Ohio. He was a member of the American College of Surgeons and was vice-president of the medical staff at Trinity Memorial Hospital. Doctor Rufflo also was on the medical staff of St. Francis, St. Luke, and West Allis Memorial hospitals.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are four daughters, Jeanne, Theresa, Suzanne, and Christine, and a son, Michael, all of Milwaukee.

Joseph F. Shimpa, MD, 73, Madison, died Oct. 15, 1970, in Boscobel.

Born on Nov. 28, 1897, Doctor Shimpa graduated from Rush Medical School, Chicago, in 1922. He practiced pediatrics in Milwaukee before entering military service during World War II. In 1946, he became associated with the Veterans Administration Hospital in Cheyenne, Wyo., where he specialized in internal medicine and became chief of medical services until his retirement in 1965.

Surviving are his widow, Lois, and a daughter, Mrs. Charles Pearson, Cheyenne, Wyo. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 30, 1970

NEW MEMBERS

Banker, Vincent P., 7310 Wellaner Dr., Wauwatosa 53213
Baylon, Renato R., Oxford Medical Center, Oxford 53952
Ferrer, Modesto M., P.O. Box 308, Rio 53960
Handrich, Thomas A., 11132 North Riverland Ct., Mequon 53092
Hinck, Vincent C., 1300 University Ave., Madison 53706
Hussa, John F., Route 6, Hayward 54843
Hussey, John L., 5622 Old Middleton Rd., Madison 53705
Konsek, John P., 211 North Commercial St., Neenah 54956
Kunin, Calvin M., 2500 Overlook Terr., Madison 53705
Peters, Howard R., 130 East Walnut St., Green Bay 54301
Raduege, William E., Bruce 54819
Rose, James W., Jr., 1313 Fish Hatchery Rd., Madison 53715
Siegert, Robert F., 5625 Washington Ave., Racine 53406
Simonson, M. James, 400 Ceape Ave., Oshkosh 54901
Strapon, Paul, III, Route 6, Hayward 54843
Viste, Kenneth M., Jr., 116 South Commercial St., Neenah 54956

CHANGE OF ADDRESS within a city

Banda, Pedro N., 6030 West Capitol Dr., Milwaukee 53216
Baumgartner, James F., P.O. Box 178, West Bend 53095
Bell, John M., 2500 Hall Ave., Marinette 54143
Beltran, Juan C., 1146 Grant St., Beloit 53511
Burpee, George F., 5 Henry St., Edgerton 53534
Dewitt, Robert J., 2500 Hall Ave., Marinette 54143
Donahue, Parnell, 1004 East Sumner St., Hartford 53027
Glesne, Orvin G., 1969 West Hart Rd., Beloit 53511
Greischar, Robert L., 804 East Irving Ave., Oshkosh 54901
Healy, William G., 500 West Milwaukee St., Janesville 53545
Hoelscher, Kenneth K., 7813 North 60th St., Milwaukee 53223
Holmes, John F., 11 Vernal Ave., Milton Junction 53564
Hughes, John B., 645 Doctors Ct., Oshkosh 54901
Jiroch, John T., Route #4, Manitowoc 54220
Jurgens, George H., 10437 Watertown Plank Rd., Milwaukee 53226
Kempthorne, Gerald C., P.O. Box 466, Spring Green 53588
Kleppe, Lars W., 1969 West Hart Rd., Beloit 53511
Koepp, Charles E., 2500 Hall Ave., Marinette 54143
Love, Robert G., 805 South Dousman St., Prairie du Chien 53821
McDonald, Donald H., 19 South 3rd St., Winneconne 54986
Morbeck, Floyd E., P.O. Box 178, West Bend 53095
Moss, Kenneth J., 2500 Hall Ave., Marinette 54143
Nielsen, William A., P.O. Box 178, West Bend 53095
Peck, Donald D., 215 Jackson, Omro 54963
Pinegar, Kenneth G., 2500 Hall Ave., Marinette 54143
Pinkerton, John D., 2500 Hall Ave., Marinette 54143
Reifenrath, Isadore B., 10425 West North Ave., Milwaukee 53226
Roesler, Marvin J., Route 5, Box 158, North Shore Dr., Delavan 53115
Roth, Harry, 310 North Yellowstone Dr., Madison 53705
Samuelson, Clarence, 123 Lawn St., Hartland 53029
Sorensen, Richard F., P.O. Box 178, West Bend 53095
Talens, Antonio C., 614 Quarry Lane, Neenah 54956
Taugher, Philip J., 5597 Apricot, Greendale 53129
Wong, James R. P., 505 South Beaumont St., Prairie du Chien 53821

CHANGE OF ADDRESS from city to city

Alt, Thomas H., Minneapolis, Minn., to 6001 Wyngate Lane, Minnetonka, Minn. 55343
Becker, Robert M., Inglewood, Calif., to 100 South Mentor Ave., Pasadena, Calif. 91106
Evrard, John R., Berkeley, Calif., to 10 Arnold St., Providence, R. I. 02906
Frawley, Donald D., Milwaukee, to 10802 Kelso Dr., Sun City, Ariz. 85351
Heersman, James R., Marshfield, to 117 North 10th St., Mt. Vernon, Ill. 62864
Ludwig, Erwin P., Wausau, to Route 2, Box 124, Wild Rose 54984
Maloney, John D., Madison, to 1028 Elizabeth St., Ft. Collins, Colo. 80521
Nereim, Theodore J., Madison, to P.O. Box 65, Mount Horeb 53572
Pettera, Robert L., APO San Francisco 96438, to Student Detachment, C & GSC, Fort Leavenworth, Kansas 66027
Young, William N., Milwaukee, to Route 2, Box 163, East Troy 53120

DEATHS

Shimpa, Joseph F., nonmember, Oct. 15, 1970
Geist, Frederick D., nonmember, Oct. 18, 1970
Lamal, André H., Ashland–Bayfield–Iron County, Oct. 31, 1970
Sargeant, Harry W., Milwaukee County, Nov. 9, 1970
Rosekrans, Sarah D., Clark County, Nov. 15, 1970
Pizer, Jerome A., Milwaukee County, Nov. 18, 1970
Rufflo, Robert A., Milwaukee County, Nov. 18, 1970 □

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

ESSENTIALS OF CLINICAL ENDOCRINOLOGY
By Norman G. Schneeberg, MD. The C. V. Mosby Co., St. Louis, Mo. 1970. 449 pages. Price: $22.50.

SYNOPSIS OF ANATOMY
By Liberato J. A. DiDio, MD, PhD. The C. V. Mosby Co., St. Louis, Mo. 1970. 530 pages. Price: $17.75.

PROGESTERONE: Its Regulatory Effect on the Myometrium (Ciba Foundation Symposium)
Edited by G. E. W. Wolstenholme and Julie Knight. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 1969. 195 pages.

BREATHING: HERING–BREUER CENTENARY SYMPOSIUM (Ciba Foundation Symposium)
Edited by Ruth Porter. The Williams & Wilkins Co., 428 E. Preston, Baltimore, Md. 21202. 1970. 402 pages.

THE FROZEN CELL (Ciba Foundation Symposium)
Edited by G. E. W. Wolstenholme and Maeve O'Connor. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 1970. 316 pages.

CONTROL PROCESSES IN MULTICELLULAR ORGANISMS (Ciba Foundation Symposium)
Edited by G. E. W. Wolstenholme and Julie Knight. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 1970. 424 pages.

THE EARLY ORTHOPAEDIC SURGEONS OF AMERICA
By Alfred Rives Shands, Jr., MD. The C. V. Mosby Co., St. Louis, Mo. 1970. Price: $15.00. 190 pages.

CHILD ABUSE LEGISLATION IN THE 1970's
By Vincent De Francis, JD, Director of the Children's Division, The American Humane Association, Denver, Colo. 1970. □

trends
The Wisconsin Regional Medical Program, Inc.

JANUARY, 1971

Washington Site Team Evaluates WRMP For Possible $200,000 Development Award

Award Would Give WRMP Control of Program Spending

SITE VISIT — Representatives of Regional Medical Programs Service, Washington, D.C., visited WRMP last month to evaluate its activities and operation. The team came at the invitation of WRMP in its application for a $200,000 developmental award. If approved, it would be one of the first awards of its kind made to an RMP. Notification is expected about February 1.

Representatives of Regional Medical Programs Service, Washington, D.C., visited WRMP for two days last month to evaluate its activities and operation. The site visit was made at the invitation of WRMP in its application for a $200,000 developmental award.

If approved, the award would be one of the first presented to a Regional Medical Program. It can be used for developmental programs in the region and expended as necessary by WRMP with approval of the Regional Advisory Group without requiring additional approval of Regional Medical Programs Service in Washington, D.C.

The RMPS site visit team consisted of: Russell B. Roth, M.D., vice speaker of the House of Delegates of the American Medical Association; Edmund J. Lewis, Thorndike Memorial Laboratory (Boston City Hospital); Joseph T. Jewell, Grants Review Branch, Regional Medical Programs Service, Washington, D.C.; Maurice C. Ryan, Chicago Public Health Service Regional Office, Chicago; Frank G. Zizlavsky, Regional Development Branch; and Lyman G. VanNostrand, Planning Branch, Regional Medical Programs Service, Washington, D.C.

The site visit team noted that the purpose of the visit was not to evaluate each and every project of WRMP but to evaluate the overall program and its relationship to the region. Emphasis was placed on the strategy used to determine the utilization of funds, ways in which the award can be used to open the way for new opportunities for WRMP and how WRMP plans to use the funds in helping solve some of the crucial health problems of the Wisconsin Region.

Dr. John S. Hirschboeck, WRMP Coordinator, noted that, if the award is made, it will give the representatives of the Wisconsin Region — members of the Regional Advisory Group — an opportunity to make decisions on the spot regarding the funding of programs rather than just giving approval to them as in the past.

"This is an opportunity for everyone involved in WRMP to do something from the very start and watch it through its completion," he said. "Until now, we endorsed it, sent it to Washington and kept our fingers crossed. If we receive the developmental award we won't have to cross our fingers. We will be able to provide immediate answers to those people requesting funds for programs."

Dr. Hirschboeck noted that greater personal interest on the part of the RMP committee members is also expected.

"It stands to reason that the more authority and responsibility you have, the greater the interest," he continued. "This 'full authority' and 'full responsibility' concept that Regional Advisory Committee Regional Advisory Group members would assume because of the complete control they would have over the programs will require more in-depth study of the overall health problems in the Wisconsin Region."

Future Role of RMP's Could Include Entire Health System

The role of Regional Medical Programs may be shifting, shifting because of the great need for improvement of the entire health care system.

Harold Margulies, M.D., acting director of Regional Medical Programs Service, has made it a point to emphasize the "new role" concept of Regional Medical Programs in several speeches given in recent weeks.

"Regional Medical Programs are a new kind of social institution," Dr. Margulies said at a recent meeting of the Western New York RMP. "They provide technical and financial support to private agencies and are in a unique position to serve as a bargainer in improving health care delivery."

He added that Regional Medical Programs are concerning themselves more broadly with the overall quality of health care in their areas.

Regional Medical Programs are a sort of political-social instrument in which there is a working relationship between the Federal structure and a private system, Dr. Margulies said at the annual meeting of the Iowa RMP. This permits the latter to work comfortably in producing progressive changes in the health care system of which it is a part, and do it entirely on an autonomous, self-directed basis with Federal funds and Federal cooperation.

DR. HAROLD MARGULIES

There is nothing else in the entire political system that has the characteristics of a Regional Medical Program, he added. Therefore, it is a very important model for determining whether that kind of arrangement will or will not work. Also, in the interest of our present move from centralization of government function toward greater dependence on local competence, the concept of Regional Medical Programs is being looked at as a possible pattern for accomplishing decentralization at both the Federal and state levels.

Mr. T. A. Duckworth, WRMP President and vice-president and secretary, Employers Insurance of Wausau, said Dr. Margulies' approach regarding the functions of Regional Medical Programs is logical and sound.

"We must move in the direction of 'programs' rather than individual 'projects,'" he said. "This is the only way we can put our mark of quality and excellence on the health care system for the Wisconsin Region rather than seeing how the needs of Wisconsin fit into the needs of the nation.

T. A. DUCKWORTH

"As Dr. Margulies stated, an effective health care system must be established based on a community's concern for changing its internal, societal responsibilities in a positive way," Duckworth noted. "The strength of our nation is in the communities where people have learned to live together and where there is a concern for the issues and problems at home. We must move away from Federally directed activities and toward autonomous responsibilities on the part of Regional Medical Programs. With the help and direction supplied by Dr. Margulies this completely autonomous capability of operation at the local level will be achieved."

President Nixon Extends RMP Three More Years

President Nixon signed a $ billion health bill recently wh includes a three year extension a a $525 million three year appropr tion for the activities of all Regi al Medical Programs.

The bill emerged from a jo conference committee of the Ho and Senate authorizing RMP a propriations of $125 million 1971, $150 million for 1972 a $250 million for 1973.

This compares to $93.5 milli appropriated in 1970.

It was noted, however, that "a thorizing" the funds does not nec sarily mean the monies will available for RMP health progran The authorization maximizes t amount that can be provided f RMP programs.

In the new bill, Regional Me ical Programs and Comprehensi Health Planning remain as separa entities. It requires, however, th they cooperate in all health ca activities wherever and whenev possible.

Emphasis is given to the regio alization of health care resourc and services in order to strengthe and improve primary care and th relationship between primary ca and specialized care. Emphasis also placed in helping those peop in areas with limited health servic in an effort to make health ca more available and accessible to a people. Too, kidney disease wa added to Public Law 89-239 whic included only heart disease, strok cancer and related diseases.

New Executive Committee Named

The Regional Advisory Grou met in Madison last month to elec a new Executive Committee fo 1971. The new members are: Mrs Robert E. Dineen, Milwaukee Harold E. Helterhoff, Minocqua Edwin J. Klag, Wood; Edward J Lennon, M.D., Milwaukee; Russel F. Lewis, Marshfield; Thomas C Meyer, M.B.B.Ch., M.A.C.P (Edin.); E. J. Nordby, M.D. Madison; Adele G. Stahl, R.N. Madison; Rodney Lee Young, J.D. Ladysmith.

VA Hospitals Linked To "Dial Access"

About 150 Veterans Administration hospitals have been linked to WRMP's "Dial Access Program." The announcement was made by Dr. John S. Hirschboeck, Program Coordinator.

The "Dial Access Program" is the first WRMP program to be linked directly with facilities on a nationwide basis. Other WRMP programs are considering regionalized activities but are not expected to seek nationwide cooperation.

Besides the link with the Veterans Administration hospitals, the "Dial Access Program" library has made its tapes available to numerous RMP's and medical schools throughout the country at a nominal cost. Included are RMP's in Arizona, Arkansas, Alabama, Northwestern Ohio, Oklahoma, New Mexico, Central New York, North Carolina, Utah (Intermountain), New Jersey and Missouri. Several medical schools have also secured all or part of the access medical library.

The "Dial Access Program" is operated in cooperation with the University of Wisconsin-Extension and Medical Centers in the Region.

Medical Tribune To Feature WRMP

The Wisconsin Regional Medical Program will be featured in a two-page picture story in the Medical Tribune on March 3. The picture feature will accompany an editorial by Dr. John S. Hirschboeck, WRMP Program Coordinator.

Planning Committee Renamed By Group

The Planning Committee had its name changed to Steering Committee recently as a result of action taken by the Regional Advisory Group.

Along with the name change, the goals and objectives of the Committee were also changed to meet the needs of WRMP programs.

The new charge given to the Committee includes the identification of areas for development, Advisory Group goals and objectives and ways to implement them, and to recommend specific tasks to Advisory Group subcommittees.

Kay Horswill, R.N., Joins WRMP Staff

Miss Kathleen M. Horswill, R.N., has joined WRMP as Assistant Nursing Coordinator, according to Dr. John S. Hirschboeck, WRMP Coordinator.

Miss Horswill will be working with Mrs. Norma M. Lang, R.N., Nursing Coordinator, on a part-time basis while still holding her position as an instructor in public health nursing, School of Nursing, University of Wisconsin, Madison.

Born in Black River Falls, Miss Horswill is a graduate of St. Francis School of Nursing, LaCrosse, and Marquette University. She received her master's degree in public health nursing from the University of Minnesota in 1967.

She has served as a staff nurse at St. Francis Hospital, LaCrosse; Stanford University Hospital, San Francisco, Calif.; Municipal Hospital, Cheyenne, Wyo.; Army Hospital, Camp McCoy, Wis.; Fitzsimmons Army Hospital, Denver, Colo.; Supervisor, Oak Forest Sanitorium, Onalaska, Wis.; Head Nurse, Wood Veterans Hospital, Wood, Wis.; Ass't Supervisor, County Health Department, Waukesha, Wis.

Comprehensive Health Planning Districts Realigned

DR. HIRSCHBOECK TO MODERATE HEALTH SERIES

Milwaukee radio station WEMP, in cooperation with WRMP, will sponsor a series of 15 minute programs entitled "Focus on Your Health," beginning February 13 at 7:30 p.m.

Each program will be focused on a specific area of health care of interest and importance to everyone in the community.

Dr. John S. Hirschboeck, WRMP coordinator, will be the moderator of the program, Mr. Leo E. Suycott, president of Wisconsin Blue Cross and Richard Randall, WEMP News Department, will be guests on the program. Each program will have a special guest considered an expert in the field being discussed.

The program schedule through April is as follows:

February 13 — "Why Does Southeastern Wisconsin Need a Medical Center?"
Guest — John L. Doyne, Milwaukee County Executive

February 20 — "What Can Be Done About The Shortage of Health Workers?"
Guest — Dr. Robert Coye, Ass't Dean, UW Medical School; Chairman, CHP Manpower Committee

February 27 — "What's Being Done About Drug Abuse?"
Guest — Dr. Basil Jackson, Assoc., Prof., Medical School of Wisconsin

March 6 — "Why Does Health Care Cost What It Does?"
Guest — Mr. Michael W. McManus, Executive Director, Milwaukee County Medical Society

March 13 — "Crisis In Blood"
Guest — Dr. Richard H. Aster, Director, Milwaukee Blood Center

March 20 — "Where Are We In Preventive Care?"
Guest — Dr. Sidney Shindell, Professor — Preventive Medicine, Medical School of Wisconsin

March 27 — "The Ability of The Hospital To Deliver Adequate Care"
Guest — Mr. Harold Guntner, Exec. Dir., Hospital Council of Greater Milwaukee

April 3 — "Alcoholism — How Widespread Is It?"
Guest — Mr. Arcadius Maroti, Executive Director, DePaul Rehabilitation Center

April 10 — "What Is Being Done About The Shortage Of Doctors In Wisconsin?"
Guest — Dr. Edward Lennon, Assoc., Professor of Medicine, Medical School of Wisconsin

April 17 — "Mental Illness — America's No. 1 Health Problem"
Guest — Dr. Charles Landis, Dir., Mental Health Center, Milwaukee County Institutions

April 24 — "New Ideas in Organization and Delivery of Health Care"
Guest — Dr. Fred Tavill, Chairman of Community Medicine, Medical School of Wisconsin

Trends is published quarterly by The Wisconsin Regional Medical Program, Inc., 110 E. Wisconsin Ave., Milwaukee, Wis. 53202. Articles for publication can be sent to the above address in care of Director, Public Information.

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Medical Society Again Hosts RMP Advisory Committee

The final meeting of the year for the Regional Advisory Group was held at the State Medical Society of Wisconsin. Those members attending the meeting included: (left to right) Mrs. Warren Lensmire, executive director, Central Wisconsin Economic Opportunity Committee, Inc., Stevens Point; Kenneth D. Clark, staff representative, Wisconsin State AFL-CIO, Milwaukee; Robert H. Steuck, assistant to the president, LaCrosse State University, LaCrosse; Mrs. F. Jackson Stoddard, Milwaukee; Perry P. Cohn, D.D.S., representative, Wisconsin State Dental Society, Milwaukee.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Mar. 12–19: Marquette Medical Alumni Association Clinical Conference, Maui Hilton Hotel, Kaanapali Beach, Maui, Hawaii. (Info: Mr. Robert H. Herzog, Exec. Secy., MMAA, 561 No. 15th St., Milwaukee, Wis. 53233)

Mar. 17: In-Depth Teaching Program—*At the Bedside,* State Medical Society of Wisconsin and University of Wisconsin Medical Center, St. Mary's Hospital Medical Center, Madison.

Mar. 19–20: Meeting of Central States Society of Industrial Medicine and Surgery, Play Boy Club, Lake Geneva.

Mar. 27: Third Annual Southeastern Wisconsin Cancer Conference on "Carcinoma of the Ovary," Ramada Sands Inn, Milwaukee. Info: J. J. Gramling, MD, Chairman, St. Joseph's Hospital, 5000 West Chambers St., Milwaukee, Wis. 53210.

Apr. 1–3: Pediatric Immunology—A Conference on Inappropriate Immunity, Department of Postgraduate Medicine of University of Wisconsin Medical Center, Wisconsin Center, Madison.

Apr. 2: Annual Conference, Wisconsin Tuberculosis and Respiratory Disease Association, Pfister Hotel, Milwaukee.

Apr. 3: Annual Meeting, Wisconsin Thoracic Society, Pfister Hotel, Milwaukee.

May 3–5: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 10–12: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Pfister Hotel, Milwaukee.

May 11–12: Wisconsin Clinic Managers Meeting, Pfister Hotel, Milwaukee.

Aug. 5–28: Scandinavian/Russian Holiday, Wisconsin Alumni Association. Info: Wisconsin Alumni Tours, 650 N. Lake St., Madison, Wis. 53706.

Oct. 17–23: Wisconsin Work Week of Health.

1971 NEIGHBORING STATES

Mar. 3–6: Twenty-third Annual Midwest Clinical Conference of the Chicago Medical Society, McCormick Place, Chicago, Ill. Info: T. J. Sacks, Director, Chicago Medical Society, 310 S. Michigan Ave., Chicago, Ill. 60604.

Mar. 15–26: Course in Laryngology and Bronchoesophagology, Eye and Ear Infirmary of the University of Illinois Hospital and the Abraham Lincoln School of Medicine of the College of Medicine, University of Illinois at the Medical Center, Chicago.

Mar. 17: Second International Symposium on Early Disease Detection, University of Chicago's Center for Continuing Education, Chicago, Ill.

Mar. 18–20: Continuation Medical Course in Psychiatry, University of Minnesota, Nolte Center for Continuing Education, Minneapolis, Minn.

Mar. 19–20: Third Annual Conference on Brief Psychotherapy, "Behavior Therapy," Department of Psychiatry and Behavioral Sciences, Chicago Medical School/University of Health Sciences and Mount Sinai Hospital Medical Center, Chicago, Ill.

Mar. 30–Apr. 3: American College of Radiology, St. Louis, Mo.

Apr. 26–28: Great Lakes Health Congress, Health Industries Association/Mid-America Nursing Home Association/Tri-State Hospital Assembly, McCormick Place-on-the-Lake, Chicago. Info: Great Lakes Health Congress, c/o Tri-State Hospital Assembly, 400 North Michigan Ave., Chicago, Ill. 60611; tel. (312) 321-0317.

May 16–19: 131st Annual Convention, Illinois State Medical Society, Arlington Park Towers, Arlington Heights, Ill.

May 17–19: Annual Convention, Minnesota State Medical–Association, St. Paul Hilton Hotel, St. Paul, Minn.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

1971 OTHERS

Mar. 1–6: Society for Cryosurgery, Diplomat Hotel and Country Club, Hollywood, Fla. Info: Mary Trueblood, Secretary, Society for Cryosurgery, 30 N. Michigan Ave., Chicago, Ill. 60602.

Mar. 3–4: Course in "Nursing," Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Mar. 7–12: PG course on "Problems and Approaches to the Diagnosis and Management of Cardio–pulmonary Failure," American College of Chest Physicians, Miami Beach, Fla.

Mar. 8–11: 34th annual meeting, The New Orleans Graduate Medical Assembly, Roosevelt Hotel, New Orleans, La. (Details appear in an ad elsewhere in this issue.)

Mar. 10–11: Postgraduate course in Urology, Cleveland Clinic Educational Foundation, Cleveland, Ohio.

Mar. 12–19: Sixth Annual Marquette School of Medicine Clinical Conference, Maui Hilton Hotel, Maui, Hawaii.

Apr. 5–7: North American sectional meeting, American College of Surgeons, Montreal, Canada.

Apr. 19–21: Annual spring session, American Academy of Pediatrics, St. Louis, Mo.

Apr. 19–22: American Industrial Health Conference, The Marriott, Atlanta, Ga.

Apr. 21–23: "Management and Care of Respiratory Insufficiency," University of Colorado School of Medicine, Denver.

Apr. 30–May 20: Spring Postgraduate Medical Seminar Cruise to the Mediterranean, Department of Postgraduate Medicine of Albany Medical College, New York.

May 1–2: 19th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, Civic Auditorium, San Francisco, Calif. Info: Donald F. Richardson, 79 West Monroe St., Chicago, Ill. 60603.

May 7–9: Medical Legal Conference, American College of Legal Medicine, Royal Orleans Hotel, New Orleans, La. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

May 10–12: Annual Meeting, American College of Sports Medicine, Toronto, Canada. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706; tel.: area code 608/262–3632)

May 17–19: Second National Conference on Breast Cancer, American Cancer Society, Century Plaza Hotel, Los Angeles, Calif.; info: Esther Kelley, Professional Education, ACS, Inc., 219 East 42nd St., New York, N.Y. 10017.

May 19–21: Annual "Topics in Internal Medicine" course, University of Florida College of Medicine, Gainesville.

May 24–26: Pharmaceutical Manufacturers Association, annual convention, White Sulphur Springs, W. Va.

May 24–28: Fifth Postgraduate Course in the "Care of Spinal Cord Injury Patients," Veterans Administration Hospital, Long Beach, Calif. Applications to: Dr. Erich G. Krueger, Director of Spinal Cord Injury Service (127), VA Central Office, 810 Vermont Ave., N.W., Washington, D.C. 20420, before April 1.

June 7–11: Annual convention, Catholic Hospital Association, Atlantic City, N.J.

June 21–26: Annual General Practice Review, University of Colorado School of Medicine, Estes Park.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Nov. 15–18: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, 307 No. Charter St., Madison, Wis. 53715)

1971 AMA

Mar. 26–27: 24th National Conference on Rural Health, Atlanta Marriott Motor Hotel, Atlanta, Ga.

Apr. 2–3: Fifth National Congress on the Socio–Economics of Health Care, Caesars Palace, Las Vegas, Nev.

June 20–24: AMA Annual Session, Atlantic City, N.J.

Aug. 30–31: Congress on Occupational Health, Jackson Lake Lodge, Wyoming.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 3: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

For listing of other meetings see the **Journal of the American Medical Association.**

Socio–Economics of Health Care—Las Vegas

The Fifth National Congress on the Socio-Economics of Health Care will be held April 2–3 at Caesars Palace in Las Vegas, Nev.

Sponsored by the Council on Medical Service, Division of Medical Practice, American Medical Association, the conference will explore existing projects and programs designed to improve physician productivity and promote efficiency in the health care system by—*Examining foundations for medical care—their concepts and operations,* and *Investigating electronic data processing applications to the economics of health care.*

The conference also will identify the status of federal legislation and its potential impact on the organization, financing, and delivery of health services.

Info: Secretary, Council on Medical Service, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Spinal Cord Injuries—Long Beach

The Veterans Administration has announced its Fifth Postgraduate Course in the "Care of Spinal Cord Injury Patients" to be held in the VA Hospital in Long Beach, Calif., from May 24 to May 28.

The course is limited to about 50 participants and is mainly designed for physicians in the Armed Forces or in non-federal medical institutions. Especially invited are neurologists, physiatrists, and specialists in neurological, urological, orthopedic, plastic and general surgery.

Applications should be submitted to Dr. Erich G. Krueger, Director of Spinal Cord Injury Service (127), VA Central Office, 810 Vermont Avenue, N. W., Washington, D. C. 20420, before April 1.

No tuition or registration fee is required.

Chicago Medical Society's Clinical Conference

A program geared to the needs of the physician or surgeon has been planned for the 27th annual Midwest Clinical Conference of the Chicago Medical Society. The meeting, on March 3–6, will be held at the new McCormick Place. It is expected to draw 4,000 medical leaders representing virtually every segment of the profession.

Among the highlights of the 4-day program are:

—An all-day session entitled, "Crisis in the Emergency Room," arranged by Sam Banks, MD, of the Trauma Committee of the American College of Surgeons.

—Several instructional courses in the areas of Internal Medicine Surgery, and Obstetrics and Gynecology, arranged through the services of Phillip Freedman, MD, professor and chairman, Department of Medicine, Chicago Medical School; Robert Freeark, MD, chairman, Department of Surgery, Loyola University Stritch School of Medicine; and John G. Masterson, MD, vice president for the Medical Center, Loyola University Stritch School of Medicine.

—A special session on Alternatives to the Pill, Surgery and Abortion.

—A panel on Non-Cancerous Problems of the Breast, programmed by the Chicago Society of Plastic Surgery.

—A panel discussion on "Drugs—Problems of Behavior" arranged through the services of Leroy P. Levitt, MD, dean of Chicago Medical School.

—In addition, there will be sessions on Practice Management, Money Management, and Parliamentary Procedure. Running concurrently with the various sessions will be a specially selected series of recent films on medical subjects, arranged by John M. Beal, MD. For the ladies, there will be a two-part session on "What Every Doctor's Wife Should Know"—the first relating to problems of wills and inheritance, and the second on matters of disposition of a practice.

The concluding session, Saturday, entitled "Futurology", will consider such questions as "What Can We In Medicine Expect", and "How Can We Influence What's Coming or At Least Prepare For It."

American Academy of Pediatrics—St. Louis

Deviant voice as a symptom of physical and emotional disorder in children, the pediatrician's role in ecology, intensive care units for high risk infants—concepts and relationship to the community, and pediatric evaluation

and management of learning and behavioral disorders (including drug therapy) are among the subjects scheduled to be presented during the annual spring session of the American Academy of Pediatrics, April 19–21 in St. Louis, Mo.

More than 2,000 persons, including pediatricians, their families and guests, are expected to attend the meeting in the Chase–Park Plaza Hotel.

The meeting will also feature approximately 90 scientific and technical exhibits, as well as informative round-table discussions on learning disorders-practical evaluation, allergy, neonatology, radiology, hematology, and neurology. Other round-table topics to be presented include: Immunology, psychosocial problems of adolescence, gastroenterology, fluid and electrolytes, and pediatric ophthalmology: genetics, strabismus and neuro-ophthalmology.

In addition, a round-table presentation on national health insurance co-sponsored by the Committees on Third Party Payment Plans and Legislation of the AAP Council on Pediatric Practice will be featured.

An allied health manpower conference entitled, "Who Will Take Care of Tomorrow's Children?" is scheduled for 9 a.m. to 5 p.m. on Sunday, April 18, at the Chase-Park Plaza Hotel. The conference will emphasize the health care delivery approach in regard to child health care. The program will include presentations by practitioners and consumers, and feature demonstrations of various health care delivery models in the private and public sectors.

The Academy, headquartered in Evanston, Ill., is the Pan-American Association of Physicians certified in the care of infants, children and adolescents.

Geriatrics Society Meeting in Chicago

The American Geriatrics Society will hold its 28th annual meeting April 23–24 in Chicago at the Ambassador Hotel. Scientific sessions include a report on the National Coronary Drug Study by Jeremiah Stamler, MD, Chicago. Further info: Edward Henderson, MD, Executive Director, AGS, 10 Columbus Circle, New York, N.Y. 10019.

American College of OB–GYN—San Francisco

The Nineteenth Annual Clinical Meeting of the American College of Obstetricians and Gynecologists will be held in San Francisco, May 3–6.

The program will develop three themes, Perinatology, Pelvic Infections, and Diseases of the Vulva, one each day. The general sessions, seminars, correlated seminars, round tables, and reports on clinical investigations will each relate to the day's theme.

Non-fellows may register to attend both the meeting and the postgraduate courses which precede the meeting on May 1 and 2.

Contact: Donald F. Richardson, 79 West Monroe Street, Chicago, Ill. 60603. □

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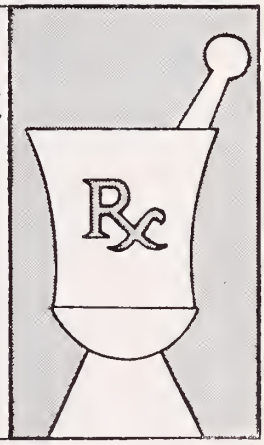

WISCONSIN STATE DENTAL SOCIETY—INVITATION

Members of the State Medical Society of Wisconsin are cordially invited to attend the 101st Annual Session of the Wisconsin State Dental Society at the Milwaukee Auditorium, May 3–5.

The Society's program to mark 101 years of service will include a number of scientific and technical essays and exhibits which should prove interesting to members of the medical profession. Bruce, Kilbourn, Juneau, Plankinton, and Engelmann Halls will be utilized for these activities.

Your current membership card in the State Medical Society of Wisconsin will admit you to all scientific meetings and exhibits.

Medical Society guests will be warmly welcomed at the Dental Society Annual Session.

—Kenneth F. Crane, Executive Secretary
Wisconsin State Dental Society

MARK YOUR CALENDAR NOW!

1971 ANNUAL MEETING

STATE MEDICAL SOCIETY OF WISCONSIN

MAY 10–12

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Highlights of Scientific Program

THEME: ADVANCES IN TREATMENT

MONDAY, MAY 10

A.M. PLENARY SESSION—"The Spleen, Organ of Mystery: Clinical Concepts and Management"
PRESENTED BY THE SECTION ON INTERNAL MEDICINE

NOON Roundtable Luncheons: INTERNAL MEDICINE, PATHOLOGY, RADIOLOGY

P.M. INTERNAL MEDICINE, PATHOLOGY, RADIOLOGY

TUESDAY, MAY 11

A.M. PLENARY SESSION—"Problems for Everyone"
PRESENTED BY THE SECTION ON GENERAL PRACTICE

NOON Roundtable Luncheons: ALLERGY, DERMATOLOGY, NEUROLOGY, HEMATOLOGY

P.M. GENERAL PRACTICE, ALLERGY, DERMATOLOGY, NEUROLOGY, RESIDENT–INTERN PAPERS

WEDNESDAY, MAY 12

A.M. PLENARY SESSION
PRESENTED BY THE SECTION ON SURGERY

NOON Roundtable Luncheons: ANESTHESIOLOGY, OPHTHALMOLOGY, OTOLARYNGOLOGY, ORTHOPEDICS, SURGERY

P.M. SURGERY, ANESTHESIOLOGY, OPHTHALMOLOGY, OTOLARYNGOLOGY, ORTHOPEDICS

WISCONSIN MEDICAL JOURNAL
Vol. 70, No. 2 FEBRUARY 1971

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

"Physician Assistant" Role Studied at Conference

Prospects for increased use of the "physician assistant" in Wisconsin were explored at a special conference called by the State Medical Society on February 11.

Held at the State Society headquarters in Madison, the meeting brought together some 65 representatives of the medical profession, hospitals, nursing, the Medical Examining Board, legislators, attorneys, and others affiliated with governmental agencies.

The conference was proposed by the State Medical Society in its "Position Paper on Health Manpower" issued last November. The Position Paper called for evaluation of the need, training, and mechanics for identification and discipline of the growing numbers of support personnel who have come to be identified as assistants to the physician, physician assistants or Medex.

Proponents suggest that wider use of these people in patient treatment can do much to ease the health manpower shortage.

At least four conclusions came from the conference:

1. There is immediacy to the subject of physician assistants. Although physicians have long used support personnel in the treatment of the sick, there is public recognition of the need for even greater use of qualified aides in health care.
2. Another meeting is required promptly to discuss specific proposals for the use of physician assistants. (The State Medical Society has since announced that the meeting will be held at its headquarters on March 11).
3. Clarification of the delegatory authority of the physician is needed.
4. Any legislative approach to the subject should be frankly experimental and highly flexible.

The conference raised many questions: What should be the qualifications of physician assistants? What limitations can practically be imposed on the functions of the assistant and how? Should the assistant be an employee, and if so, whose?

How best can the physician be afforded protection for the delegation of certain treatment tasks? Should the assistant be granted statutory recognition, and if so, by certification or by licensure?

Lead-off speaker at the conference was Thomas E. Henney, MD, Portage, member of the State Medical Examining Board. He reported that there may be nearly 100 different types of training courses for physicians in the nation today. Five states have broadened their laws to permit physicians the use of competent assistants of various types, eight more states have the matter under consideration.

However, "at the same time, the physicians' assistant in most states

continued on page 27

State MEDIHC Program Started

Wisconsin is now participating in the nationwide program called Operation MEDIHC—Military Experience Directed Into Health Careers—a project sponsored jointly by the Department of Health, Education, and Welfare and the Department of Defense.

The two-fold program is designed to help alleviate health manpower shortages and to help returning Armed Services veterans with military medical training to enter civilian health careers.

In Wisconsin the MEDIHC program is being administered by the Wisconsin Health Council, Inc., which already supports a Health Careers Program.

The MEDIHC coordinator for Wisconsin is Mr. Frank M. Drew, 31, of Barneveld who formerly was associated with the Office of Clinical Experience for Teachers at the University of Wisconsin.

The program is being financed, in part, by tax-supported funds. In December Gov. Warren P. Knowles announced that a $10,000 grant would be released by the Department of Industry, Labor, and Human Relations to the WHC.

The MEDIHC program will operate from the State Medical Society headquarters in Madison. SMS is a member of the WHC.

Mr. Drew will be working with Mr. Howard Brower, an associate secretary of the State Medical Society of Wisconsin and the executive secretary of the Wisconsin Health Council, allowing for close coordination between the governmental and voluntary agencies who have legiti-

continued on page 26

Med Students Offered On-Site Clinical Training

Clinical experience under direct supervision of a physician in a Wisconsin community hospital setting will be offered this summer to presophomore medical students from both Wisconsin medical schools.

The State Medical Society of Wisconsin and the Wisconsin Hospital Association are cooperating with the Student American Medical Association's Wisconsin Chapter in establishing a Medical Education Community Orientation program, known as MECO.

The SAMA–MECO project, which also has the support of the American Medical Association, will give medical students an opportunity for on-site training in communities throughout the state.

The MECO students will spend ten weeks during the summer observing physicians and learning basic procedures in a community hospital and in a physician's office, rotating through a clinical program under direct supervision of the hospital medical staff.

Each student will be paid a stipend of $750 by the hospital plus room and board as necessary.

The State Medical Society has stated that the MECO project is not intended to replace or overtake any similar medical student summer program presently operating in Wisconsin communities, but rather to supplement them.

Society endorsement of the program is intended only in situations where the medical student is in a program under the direct supervision of a member of the hospital medical staff.

The SAMA–MECO program has been operating for the past two summers in a few midwestern states. This year it is expanding into 20 states, and by the summer of 1972 it is anticipated that all 50 states will be participating.

Although the main objective of the MECO project is to introduce the preclinical student to clinical medicine in a community hospital setting, as differentiated from a university-affiliated hospital, it is hoped that such an experience will stimulate the students' return to those or similar communities when they establish practices.

THREE 70-YEAR-OLD MALLARD DECOYS recently donated to the CES Foundation's duck decoy collection by D. W. Dailey, MD of Elcho are shown by Mrs. Judy Sowl. Several physicians have donated their old decoys to this unusual and fascinating collection now on display at the Society's headquarters. When completed, the duck decoy collection will be added to the "Hobbies for Health" exhibit at the Museum of Medical Progress and Stovall Hall of Health, Prairie du Chien.

MEDIHC PROGRAM

continued from page 25

mate concerns and responsibilities in meeting health care needs of Wisconsin's citizens.

Operation of the MEDIHC program involves a broad scope of activity including career counseling, liaison with the health-care disciplines, continuous inventories of the various job opportunities and where they are, close working relationships with schools—both professional and technical, methods of evaluating the skills acquired in the military in terms of their civilian counterparts, and for some careers, it will require dialogue with those agencies which license, certify, or register health and allied personnel.

Countrywide there are between 30 and 35 thousand medically trained and experienced personnel who leave the Armed Forces each year. While exact figures are not available, it has been estimated that approximately 600 will either be returning to Wisconsin or indicating the Badger State as their choice of residence upon completion of their military tour of duty.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio–economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

"Cancer Shell" Exhibit Proposed

The State Medical Society's Charitable, Educational and Scientific Foundation has proposed development of a unique exhibit that would dramatize and personalize the ways to prevent and cure cancer.

Called the "Cancer Shell," this display would spend most of its summers at the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien. It would be viewed by upwards of 40,000 persons each season.

In late 1970 the Wisconsin Division of the American Cancer Society contributed $1,000 to the CES Foundation to support the initial development.

The Beta Sigma Phi sorority chapters in Wisconsin have adopted the Cancer Shell as a major project.

A total of $25,000 is needed to develop and present this unique educational program.

The sorority hopes that its goal can be reached in time for a grand opening at the Museum on April 15.

Contributions are being accepted in a special Beta Sigma Phi Cancer Shell fund by the CES Foundation.

Designed to appeal to all ages, but with an emphasis toward the younger adult generation, the Cancer Shell would be about 20 feet across and 10 feet high. It would accommodate as many as 25 persons at a time, yet be equally effective with only one.

Through the use of sound, light, art forms and sculptured shapes, the Cancer Shell's story would be short, very "alive," a little bit of a shocker and, above all, professionally and powerfully done.

During the off-season times of the year, the Cancer Shell would be displayed at public places such as fairs, schools, museums, and the like in major Wisconsin cities.

PHYSICIAN ASSISTANT

continued from page 25

is wandering in a kind of legal limbo, his status unclear, and his right to perform duties for which he is trained, uncertain," according to Dr. Henney.

Speaking to the physicians, Dr. Henney said a major effort is required to clarify the dilemma presented in the fact that "only a licensed physician may engage in the practice of medicine."

"Which medical acts and functions may be delegated to an unlicensed person, and how close must the supervision be," Dr. Henney queried.

Ben R. Lawton, MD, Marshfield, chairman of the State Medical Society's Commission on Scientific Medicine and a surgeon who has trained and uses a non-medical surgical assistant, described his views of the duties and use of the physician assistant.

He sees the immediate future of the assistant as a "one-to-one, close and direct relationship to the physician."

Otto A. Mortensen, MD, Madison, chairman of the Society's Special Committee on the Shortage of Physicians, reported on training programs for physician assistants. Additional data needs to be gathered on the specific tasks that various types of assistants can usefully perform before realistic educational efforts can be developed, he said.

W. T. Russell, MD, Sun Prairie, chairman of the Society's Commission on Public Policy, discussed professional and legal issues along with Society Attorneys Robert B. Murphy, Madison, and John A. Kluwin, Milwaukee.

National Health Care Spending Reached $67.2 Billion in 1970

National spending for health care (public and private) increased from $59.9 billion in 1969 to $67.2 billion in 1970, according to the latest report from the Department of Health, Education, and Welfare.

In fiscal year 1970, the average health expenditure for each person in the United States was $324, up $33 from the previous year.

Other significant facts of the HEW Research and Statistics Note No. 25, 1970 were:

. . . Medicare spending in fiscal 1970 totalled $7.1 billion; spending for Medicaid is estimated at $4.9 billion.

. . . Three-fifths of all personal health care expenditures were met by third parties such as government, private health insurance, philanthropy, and industry. Government paid 58 percent of this amount.

. . . Hospital care expenditures again registered the largest increase, growing 15 percent in one year and reaching $25.6 billion.

. . . Spending for physicians' services also gained, rising 9.5 percent to a total of $12.9 billion.

. . . On a per capita basis, the average hospital expense outlay was $124, and the average expenditure for physicians' services was $62.

Confusion Cleared on UW's Two Drug Info Centers

The existence on the University of Wisconsin Madison Campus of two organizations that are both known as drug information centers has resulted in some confusion.

One of the centers is an information source for students on the Madison campus while the other functions as a statewide source for health–care professionals and the public.

In 1970 the UW Division of Student Affairs opened a Drug Information Center for the purpose of helping students become better informed about drugs.

This "Drug Information Center" is not a professional treatment or counseling center, but rather an information gathering place for students with questions about drugs.

Mrs. Frances Hurst is director, It is located at 420 North Lake Street, Madison 53706; telephone (608) 263–1737.

Since 1964 the UW Hospitals' Department of Pharmacy has operated the statewide Drug Information–Poison Control Center which functions as a statewide source of up-to-date and difficult to obtain information on drugs and their applications to patient care. Information on toxicity of poisons and drugs along with antidotes and recommended treatment of poison ingestion is a prime function of the center.

The University Hospitals' Drug Information–Poison Control Center is available 24 hours a day, 7 days a week to answer questions from physicians, pharmacists, nurses, and other health-care professionals. It can be reached at (608) 262–1315.

Wisconsin Legislative Report

BONDING OR BORROWING FOR HEALTH FACILITIES--(Bill S, 93) introduced by Sen. Lorge, authorizes city, village, and town boards of health to build medical centers, hospitals, infirmaries, doctors' offices or other medical service facilities, and to finance these by bonding or borrowing from the state school trust fund.

CHIROPRACTIC--(Bill A, 171) introduced by Assemblymen Atkinson and Looby, requires employers to make available chiropractic services under workmen's compensation and to post panels of chiropractors. It also equates chiropractors with physicians in respect to medical testimony and reports in workmen's compensation proceedings.

GENERIC DRUGS--(Bill A, 206), introduced by 34 Assemblymen and four Senators, requires all drug prescribing and prescription filling to be done by generic name.

ABORTION--(Senate Joint Resolution 8), introduced by 15 Republican Senators, proposes a constitutional convention to amend the U.S. Constitution reserving to the states the right to regulate abortion. Bill A, 161, introduced by 25 Assemblymen and 1 Senator requires that when death occurs, because of an induced abortion, the death certificate shall so state.

MENTAL HEALTH ACT--(Bill S, 51), introduced by the Legislative Council, completely recodifies the State Mental Health Act, completing work begun in 1966. Conceptual changes included are: emphasis on maintenance of mental health rather than the treatment of mental illness; drug addiction and alcoholism are no longer treated separately by law. Provisions for comprehensive community mental health services have been deleted; requirement that patients with ability to pay must be referred to private treatment sources has been dropped.

LIABILITY FOR ALCOHOL BLOOD TESTS--Under Bill A, 86, introduced by Assemblymen Brown, Mittness and McCormick, physicians and other authorized persons withdrawing blood for purposes of determining alcoholic content are exempt from civil or criminal liability, except for negligence in performance of the act.

MENTAL HEALTH--(Bill S, 52) introduced by the Legislative Council, establishes community mental health, mental retardation, alcoholism and drug abuse service boards to enable counties to develop comprehensive service programs for these conditions. No provision is made for physician membership directly on the board. Clinical treatment in such programs is to be directed by an MD trained in psychiatry; he also may be the director of the center.

NEW INCOME FIGURES FOR PROFESSIONALS show modest gains, and some slippage, according to newly released IRS figures on average net incomes reported on 1968 returns. A WALL STREET JOURNAL (Jan. 20, 1971) comparison of 1967/1968 average net taxable incomes for professionals practicing in partnerships showed the following: physicians--$36,143/$36,250, dentists--$21,886/$17,541, lawyers--$25,280/$26,419, engineers--$14,818/$13,628, and architects--$15,604/$16,008.

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MEDICAL HISTORY FEATURE

Early Radiology in Wisconsin

By J. E. Habbe, MD, FACR, Milwaukee, Wisconsin

On August 20, 1924, the House of Delegates of the State Medical Society of Wisconsin gave formal approval for the establishment of a section on Roentgenology. It was one of the earliest state medical society sections in the United States. The Milwaukee County Radiological Society had been formed just one year earlier.

The state section's organizational meeting was held October 29, 1924, in Milwaukee. There were fifteen men present, six from Milwaukee and the other nine from around the state. One Milwaukee member was an osteopathic physician; another Milwaukeean, Mr. Jacob Janssen, was a pharmacist-radiographer whose experience with medical radiography extended back to 1896.

Initially the deleterious biological effects of the x-ray were not known; nor were there any well established criteria to determine which diseases would benefit from x-radiation. Unfavorable reactions were gradually being recognized, acute reactions from single or shortly repeated large doses, and later appearing untoward reactions resulting from repeated daily small exposures such as those that occurred on the physician and his office staff. A number of physicians using the x-ray in their own practices developed degenerative changes in the hands and fingers; some required amputations to prevent the spread of skin malignancies.

One of the earliest papers to be presented on x-ray diagnosis was by Dr. William Sickels of South Milwaukee. On January 27, 1903, he gave a lecture on "Skiascopy of the Respiratory Organs."

A year later, on June 23, 1904, Dr. Louis Frank, a dermatologist of Milwaukee, presented a paper before the State Medical Society of Wisconsin on "Therapeutic Use of X-Ray in Dermatology." He stressed the great value of x-rays in treating skin cancers.

Dr. Otto Foerster, a Milwaukee dermatologist, presented a paper at the annual meeting of the State Medical Society of Wisconsin on August 22, 1907, in Superior. During the presentation of his subject on "X-Ray Injuries", he warned against the indiscriminate use of x-ray in treatment of acne, psoriasis, and other benign skin conditions.

Summary of a paper presented at the 44th Annual Meeting of the Wisconsin Radiological Society, Lake Geneva, Sept. 21, 1968, and published in 1970 by the WRS, Robert F. Douglas, MD, Secretary-Treasurer, 1209 South Commercial Street, Neenah, Wisconsin 54956.

The first Wisconsin persons to become members of national radiological organizations were Mr. Jacob Janssen of Milwaukee and Dr. George Steele of Oshkosh. Both were elected members of the American Roentgen Ray Society in 1902. Later, in 1918, Doctor Steele also joined the Radiological Society of North America.

In 1911, the two medical schools, existing separately in Milwaukee, joined to become the Marquette University School of Medicine.

Graduating about this time were Drs. C.A.H. Fortier and Edward Blaine who showed an interest in x-ray and electrotherapy. They equipped a downtown Milwaukee office for the practice of roentgenology and also served in a consulting capacity in the hospitals.

In Madison, Dr. Robert Drane, a 1913 graduate of the University of Pennsylvania Medical School, became the Society's first member from the University of Wisconsin faculty. He was assigned to the x-ray room. He subsequently served in the military forces, then moved to Savannah, Georgia. His successor was Dr. Howard Curl who also left the University in 1922 to become radiologist at the Sheboygan Clinic.

It was not until 1929 that the UW Medical School's dean, Dr. Charles Bardeen, invited Dr. Ernest Pohle, radiotherapist at the University of Michigan, to take charge of the x-ray service.

Meanwhile in Milwaukee, Dr. Harry Podlasky, a Jefferson Medical school graduate who had had radiologic training during the World War I years, was named associate professor of radiology at Marquette University School of Medicine. He continued to head the service until his premature death at 49 years of age.

In the first several decades of the twentieth century and for a few years following World War I, most radiologists carried on solo practices, often combining hospital service during the morning hours with afternoon practice in a private office. But by the beginning of World War II, some practices had grown to the point where associates were needed.

Founder Members. Dr. Frank Mackoy (1880–1954) of Milwaukee was one of the first to perceive a state radiologic group within the structure of the State Medical Society of Wisconsin. He served for many years as both diagnostic radiologist and gastroenterologist at the Milwaukee Sacred Heart Sanitarium.

Dr. Harry Podlasky (1884–1935) of Milwaukee had a general practice until World War I after which he opened an office for the practice of radiology. He was appointed radiologist for Mt. Sinai Hospital.

Dr. Roy Potter (1879–1970) of Janesville combined an office practice of radiology with anesthesiology at Mercy Hospital. He also served many years on the State Board of Health and was its president from 1960 to 1965.

Dr. Charles Bardeen (1871-1935) of Madison was one of the Wisconsin Radiological Society's most distinguished members. He went to Madison in 1904 and was named professor of anatomy at the University of Wisconsin. He subsequently became the first dean of the medical school. For some years he was interested in relating x-ray measurements of the heart to height and weight of the patient. He worked with neophyte radiologists Paul and Fred Hodges.

Dr. Manly Sandborn (1869–1926) of Appleton was the only Wisconsin radiologist to be honored with a founder fellowship in the American College of Radiology in 1923. In 1925 he was named president-elect of the Radiological Society of North America but succumbed during surgery before he could preside at the next meeting in Milwaukee in November–December 1926. □

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References:
1. Duvoisin, R. C., *et al.*: *Trans. Amer. Neurol. Assoc.*, *94*: 81, 1969.
2. Cotzias, G. C.: *J.A.M.A.*, *210*:1255, 1969.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

HERNIA REPAIR WITHOUT DISABILITY

By Irving L. Lichtenstein, MD. The C. V. Mosby Co., St. Louis, Mo. 1970. 210 pages. Price: $26.50.

THE IMMUNOLOGY OF MALIGNANT DISEASE

By Jules E. Harris, MD and Joseph G. Sinkovics, MD. The C. V. Mosby Co., St. Louis, Mo. 1970. 251 pages. Price: $15.00.

THE FACE IN GENETIC DISORDERS

By Richard M. Goodman, MD and Robert J. Gorlin, DDS. The C. V. Mosby Company, St. Louis, Mo. 1970. 169 pages. Price: $19.00.

ACTION AGAINST MENTAL DISABILITY

The Report of The President's Task Force on the Mentally Handicapped. Superintendent of Documents, U. S. Government Printing Office, Washington, D.C. 20402. September 1970. 62 pages. Price: 35¢.

SCHIZOPHRENIA BULLETIN

Center for Studies of Schizophrenia, National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20015. U. S. Department of Health, Education, & Welfare, Chevy Chase, Md. 20015. 1970. 104 pages. Price: $1.00.

MODERN TREATMENT, VOLUME #3

Treatment of the Systemic Mycoses, Guest Editor: John P. Utz, MD, Treatment of Calcium Disorders, Guest Editor: Gilbert S. Gordon, MD, PhD. Medical Department, Harper & Row, Publishers, 49 East 33 Street, New York, New York 10016. May 1970. 712 pages. $20.00 per year. Published bi-monthly.

INFECTION CONTROL IN THE HOSPITAL

American Hospital Association, 840 North Lake Shore Dr., Chicago, Ill. 60611. 1970. 154 pages. Price: $4.00.

HEALERS IN UNIFORM

By Edward Edelson. Doubleday & Company, Inc., Garden City, New York, 1971. 184 pages. Price: $3.95

THE FAT-SOLUBLE VITAMINS

Edited by H. F. DeLuca and J. W. Suttie, University of Wisconsin Press, Box 1379 Madison, Wis. 53701, 1970. 531 pages. Price: $15.00

MODERN TREATMENT, VOLUME 7, #4

Female Genital Infections: Guest Editor; David Charles, MD. Special Article: Meaningful Clues and Physical Signs in Chest Disease, by David E. Dines, MD and Richard A. DeRemee, MD. Medical Department, Harper & Row, Publishers, 49 East 33 Street, New York, New York 10016, July 1970. 856 pages. $20.00 per year Published bimonthly. □

A Letter to the Secretary*

PRESIDENT'S PAGE

January 15, 1971

Mr. Elliot L. Richardson, Secretary
Dept. of Health, Education, and Welfare
Social Security Administration
Washington, D.C.

Dear Mr. Richardson:

On January 6, 1971, the *Sheboygan Press* printed an article which stated, "A Health, Education, and Welfare Department spokesman said increases are necessary to meet physicians' rising fees." He referred to the monthly premiums paid by elderly persons to cover doctor bills.

Another item in the Milwaukee paper quoted William R. Hutton, executive director of the National Council of Senior Citizens, decrying in Washington the increase in Medicare premiums necessary to meet the rising cost of doctors' bills.

"It is getting to the point where many older people are going to have to make the cruel choice of paying the Medicare premiums or doing without food."

I am sure that you are aware Mr. Richardson, that the federal government has in effect instituted price control on fees paid for Medicare patients. The net result of this is that physicians are now being paid on the basis of the 1968 rates. It is not fair to attribute the rising cost in premiums to the doctors' fees. By far the largest percentage of Medicare fees are paid to hospitals and nursing homes and, I would suggest too, that the increased cost of Medicare can be partially attributed to the increasing overhead of the Department of Health, Education, and Welfare.

Under the circumstances, I think it would be proper now to have a "spokesman" make a statement to the *Press* that the increasing payments under Medicare are not due to the increased doctors' fees.

Sincerely yours,

J. W. McRoberts, MD

JWMcR
DG

* While this was a personal letter to Secretary Richardson, I would like to share it with members of the State Medical Society in light of changing levels of reimbursement for physicians' services to Medicare patients now being imposed by the Social Security Administration.—JWMcR

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Another Smear

The Milwaukee *Sentinel,* in its January 29, 1971 issue, took the medical profession to task for what it calls fraud.

It seems that when the Milwaukee police force returned to work after a bout with the "blue flu," most of the officers brought with them notes from doctors certifying that they had been sick and therefore were entitled to be paid for the time they were absent from duty. "To add to the disgrace of policemen deserting their posts," said the *Sentinel,* "we see the possibility of some members of the medical profession endorsing such illegal action by signing certificates of illness which are not warranted."

Despite seeming to limit its attack on "some members," the *Sentinel* labeled the editorial "Medical Fraud" and called for a statutory remedy to apply to the medical profession "if an investigation deems it advisable." Presumably the pique of the city's administration at the strike of its police force would be directed against the medical profession, since obviously the city can't get tough with its own policemen.

Is the anger of the *Sentinel* justified? Perhaps. If it is angry because the policemen pulled off a successful strike, it may be justified. But there is no reason to pick on the medical profession because the police used medical excuses. In the first place, according to another news source which seems not to have reached the *Sentinel,* a very large number of the medical excuses were signed by one physician. If he did something wrong, maybe the *Sentinel* ought to go after him.

But more importantly, neither the *Sentinel,* nor apparently anyone else, seems to have checked to see what the so-called fraudulent certificates of illness actually certified. Very often, such slips merely contain a statement by a physician to the effect that the patient reported that he had been ill during a certain period of time. By no stretch of the imagination could they constitute fraudulent verification of non-existent illnesses. The *Sentinel* ought to verify its facts before it excoriates an entire profession. It may find that it owes the doctors of Milwaukee an apology.

The "blue flu" phenomenon, however, suggests that the entire matter of sick leave ought to be re-examined by employers in the face of the realities of modern life. The custom of requiring a doctor's certification of illness upon return to work in order to collect sick leave pay originated in the dawn of modern industrialism. It assumes that if an employee is sick enough to stay home from work, he should be sick enough to require medical care. Often the doctor's slip is not even read by the employer, or it may be illegible or incomprehensive—apparently no detriment. Although often meaningless, the employer continues to require it because of the "rule-is-a-rule" attitude of some personnel departments.

In order to obtain the necessary certification to return to work without loss of pay, the employee may have to take additional time off in order to get his "doctor's slip." Disabling illness of short duration, such as upper respiratory infections, are generally self-limiting and require nothing more than symptomatic treatment, usually prescribed by the physician via the telephone. Barring complications the employee could return to work in three or four days. If he must have a "doctor's slip," however, he must devote an additional day—and possibly more—to the task of personally visiting his doctor to pick up the required document. While he is there, the doctor usually conducts some sort of examination and may or may not observe the vanishing signs of the recent acute illness. His certificate can only list the date of the illness as reported to him by the patient.

In the event of serious or prolonged illness, of course, insurance forms are filled out, and return-to-work forms are useful to indicate what limitations should be placed on the employee's work. Such forms are easily obtained because the employee is seeing the doctor regularly, and the doctor is giving information of which he has first-hand knowledge.

Employers have a right to know whether or not the illness of an employee will affect his ability to perform his job. But the practice of requiring an excuse for each short absence smacks of grammar school technique: trying to keep the kids from playing hookey, with doctors unwillingly and wastefully cast in the role of mommas. Surely the employer's own medical department, or his personnel department, can make a better determination of the employee's reason for absence. It would have to be an incredibly dense personnel manager not to be able to spot chronic unwarranted absenteeism, with or without a doctor's slip.

As far as the *Sentinel* is concerned, let's hope all its employees eschew the possibility of a little fraud on their employer. If one of the *Sentinel's* editorial writers should call his doctor on the phone to describe his crashing hangover, why shouldn't his doctor believe him? And why shouldn't his doctor be willing to write a little note to the *Sentinel* stating that the patient said he was ill on that date?

But maybe the *Sentinel* is enlightened. Maybe it doesn't require of its own employees what the city of Milwaukee requires of its policemen.

—DNG

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

OPPORTUNITIES TO SERVE IN NICARAGUA

To SMS:

Opportunities for short-term service by Wisconsin physicians in rural hospitals in eastern Nicaragua are available. The Country of Nicaragua and the State of Wisconsin joined in a "sister-state" relationship several years ago. As a consequence, informal contacts and relationships have developed between the medical professions of the "sister-state." In particular, two small regional mission hospitals have been selected by medical students from U.W. and Marquette as the sites for a senior elective in International Community Health. This elective is approved for credit and is coordinated by the Department of Pediatrics at the University of Wisconsin.

During academic 1970–71 six U.W. medical students, one pediatric resident, and two Marquette medical students will have completed this three-month elective.

For practicing physicians in Wisconsin, opportunities are available to perform several roles: to assist in the teaching of U.S. medical students, to assist in clinical research projects, to assist in the delivery of health care in a developing country, and to aid in the growth of quantity and quality health service delivery in northeastern Nicaragua.

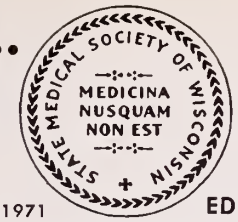
The hospitals are sponsored by the Moravian Church in the United States, and serve as regional hospitals subsidized by the Nicaraguan Department of Public Health. Directors of the hospitals are Americans who have completed surgical residency training in the United States. U.S. medications are used. Most of the nurses and hospital personnel speak English fluently. Professional qualifications are broad: any physician with general practice type experience and/or general surgery. During 1970 four Wisconsin physicians spent from three to six weeks in one of these two hospitals.

This type of experience provides an opportunity to serve in a meaningful way in the delivery of health care in a developing country and at the same time to participate in a unique educational experience for U.S. medical students.

For further details, contact:

NED WALLACE, MD
Dept of Pediatrics
1300 University Ave
Madison, Wis 53706
Tel. 301/666-3847
(after 6:00 pm)

SECTION



OPHTHALMOLOGY

FEBRUARY 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MILWAUKEE OPHTHALMIC SOCIETY MET

A symposium on Ocular Therapy was presented at the Milwaukee Ophthalmic Society meeting January 27.

Paul H. Goldstein, MD discussed treatment of corneal lacerations. The important principles stressed included satisfactory wound closure of the lacerated areas, and the importance of keeping iris, lens material, and vitreous away from the wound area. Treatment of lens trauma also was discussed.

John E. Ridley, III, MD discussed the treatment of traumatic hyphema. He stated that there is little correlation between the extent of the initial hyphema and rebleeding. Limitation of activity seems important in preventing rebleeding. The technique for the surgical treatment of complete hyphema with secondary glaucoma by irrigation of the anterior chamber with fibronolysin was discussed.

Gent J. Pawlowski, MD talked on foreign bodies in ophthalmology. Small metallic intraorbital, but extraocular foreign bodies causing no difficulty may not have to be removed. He discussed the early recognition of intraocular foreign bodies which should be removed surgically before fibrous encapsulation, or ocular chemical degenerative changes occur. The treatment of multiple deeply imbedded corneal bodies secondary to explosions was discussed.

Philip J. Taugher, MD discussed alkali burns of the eye. No treatment is very satisfactory, but immediate copious irrigation with water in combination with mechanical debridement of particles is most important. Steroids should be used with respect, and are probably contraindicated where perforation is possible. Scleral shells, particularly the soft variety, are indicated to prevent symblepharon, and to protect the cornea. Callogenase inhibitors may well be a significant forward step, but this will have to await further investigation.

NEW OPHTHALMOLOGIST IN WAUKESHA

R. R. Flickinger, Jr., MD on January 1 joined the Eye, Ear, Nose and Throat Associates, Inc. in Waukesha. Other associates are MDs J. Victor Bolger, George L. McCormick, James V. Bolger, Michael R. McCormick, and Walter E. Gager.

Doctor Flickinger received his BA degree from the University of Iowa in June 1957. He attended graduate school at the University of Iowa in June 1964. He then served a rotating internship at Latter-day Saints Hospital in Salt Lake City, Utah, from 1964 to 1965.

Doctor Flickinger started his residency in ophthalmology at the University of Iowa in July 1965. In August 1965, he was called into service, spending the next two years at the Armed Forces Examining and Entrance Station in Des Moines, Iowa, as general medical officer.

He returned to University Hospitals in Iowa City in August 1967 and completed the ophthalmology residency in December 1970.

FILM: THE GLAUCOMAS

An educational film for professional audiences entitled, "The Glaucomas," is available through the Wisconsin Society for the Prevention of Blindness, 312 East Wisconsin Ave., Milwaukee, Wis. 53202; tel. 414/272–0548, on a free loan basis.

The 23-minute, 16mm, sound film in color was produced for the education of non-opthalmologist physicians, for medical students, residents and nurses, and discusses the disease mechanism, various diagnostic techniques and, briefly, the treatment regimen.

OPHTHALMOLOGIST JOINS MILWAUKEE GROUP

Richard E. Lernor, MD, a native Milwaukeean, has joined MDs Samuel S. Blankstein, Herbert Giller, and Paul H. Goldstein in Milwaukee. Doctor Lernor graduated from Washington University School of Medicine in 1964. He did his internship at Michael Reese Hospital in Chicago, then completed a three-year residency in opthalmology at Washington University and Barnes Hospital in St. Louis, Mo., in June 1970. Following this he spent three months with Max Fine, MD in San Francisco, Calif., studying corneal transplant surgery.

MANAGEMENT OF GLAUCOMAS

MDs Elieser B. Suson and Richard O. Schultz of Milwaukee are authors of an article entitled "Management of Glaucoma," which appears in this issue of the WMJ at page 93, a COMMENTS ON TREATMENT feature.

DATES TO REMEMBER

March 23: Milwaukee Ophthalmological Society meeting. Robert Welch, MD, speaker.

April 27: Milwaukee Ophthalmological Society meeting. Charles Jaeckle, MD, speaker.

May 12: Section on Ophthalmology of the State Medical Society of Wisconsin meeting in Milwaukee. Kenneth J. Richardson, Jr., MD, Pittsburgh, Pa., speaker, on Glaucoma. □

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Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.
Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.
Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.
When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.
Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.
Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.
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PHYSICIAN BRIEFS

Peter A. H. Midelfort, MD*

. . . Eau Claire, was honored recently by the Wisconsin Medical Alumni Association for his work of more than 20 years with University of Wisconsin medical students under a preceptorship program. Doctor Midelfort was presented a Max J. Fox Preceptor Recognition Award. He was head preceptor in Eau Claire for 20 years, until 1967. His father, Hans Midelfart, MD, was one of the first Wisconsin preceptors, and headed the program here until 1937. The award was presented to Doctor Midelfort at a joint meeting of the medical staffs of Luther and Sacred Heart Hospitals. Peter L. Eichman, MD,* dean of the University of Wisconsin Medical School, and Robert Schilling, MD, president of the University Medical Alumni Association and chairman of the medical department, participated in the presentation. Donald R. Griffith, MD,* Eau Claire, is now head preceptor in the area.

Calvin O. Chicks, MD*

. . . Janesville psychiatrist, and Vedad Oge, MD, Lake Geneva psychiatrist, recently became the medical director and clinical director, respectively, at the Walworth County Mental Health Center. Instead of a full-time psychiatrist as in the past, there will be two half-time doctors to provide more availability and continuity to the counseling program.

William B. Hobbins, MD*

. . . Madison, represented Dane County at the National Conference on Cancer of the Colon and Rectum held in San Diego, Calif. Doctor Hobbins is chairman of the Professional Educational Committee of the Dane County Chapter of the American Cancer Society.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

NEWS HIGHLIGHTS

Dr. Bernhardt Named Assistant Dean, UW

Louis C. Bernhardt, MD,* Madison, recently was appointed to the post of assistant dean for clinical affairs at the University of Wisconsin Medical School. Doctor Bernhardt also is an assistant professor of surgery and director of emergency room services at University Hospitals.

Doctor Bernhardt is a graduate of the University of Wisconsin Medical School and served his internship at Mt. Sinai Hospital, Milwaukee. His residency in general surgery and thoracic and cardiovascular surgery was at University Hospitals, Madison. He is a diplomate of the American Board of Surgery.

State Medical Assistants Hold Symposium

The Twelfth Educational Symposium of the Wisconsin State Medical Assistants Society was held January 30 at the Holiday Inn in Southeast Madison.

Program speakers were: Brother Booker Ashe, director of the House of Peace, Milwaukee, who spoke on "The Spiritual and Human Relation Obligations of Medical Assisting;" Thomas C. Meyer, MD,* University of Wisconsin Medical Center, Madison, "Dial Access;" Charles A. Kelsey, PhD, associate professor of radiology, University of Wisconsin Medical Center, Madison, "New Diagnostic Techniques from Bioengineering;" and Mr. Dean Van Gordon, safety coordinator, State of Wisconsin, Madison, "The Hazards of Being a Commuter."

A movie entitled, "A Tribute to a Medical Assistant," was presented by Wyeth Laboratories.

Dr. Purtell, Jr. to Head Milwaukee GP Group

Robert F. Purtell, Jr, MD* of Brookfield was elected president-elect of the Milwaukee Academy of General Practice at the academy's annual meeting at the Pfister Hotel in Milwaukee, January 26.

Dr. Purtell will take office as president of the 250-member group of family physicians in 1972. He will succeed John O. Grade, MD* of Elm Grove, who was installed as president January 26.

Dr. Purtell, a 1961 graduate of Marquette University School of Medicine, practices with his father, Robert F. Purtell, Sr, MD* in Milwaukee. The senior Purtell was a founder and past president of the Wisconsin Academy of General Practice.

Doris M. Roob, MD of Cudahy was reelected secretary, and Nicholas DeLeo, MD* of Wauwatosa was reelected treasurer.

About 250 persons attended the annual meeting during which they heard a special presentation on preserving the private practice of medicine as opposed to government control.

New Officers Elected, La Crosse Society

A. Erik Gundersen, MD* of La Crosse was elected president-elect at a recent meeting of the La Crosse County Medical Society. Paul W. Phillips, MD* of La Crosse assumed the presidency and Charles E. Link, MD* of La Crosse was elected secretary–treasurer. Delegates to the State Medical Society are: Sigurd B. Gundersen, Jr., MD,* James T. Murphy, MD* and Duane W. Taebel, MD,* all of La Crosse.

AMA Attorney Speaks at Green County Society

Dave Powers, attorney and director of the Division of Management Services of the AMA, was the guest speaker at the Green County Medical Society meeting. He spoke on the proposals for a national program of health insurance and on malpractice insurance. The Green County Medical Society's wives were invited to the Society's annual meeting for the first time in the history of the organization.

Volunteers for Nicaraguan Mission

Stewart Griggs, MD* of Green Bay is spending a three-week volunteer tour working in the Moravian Hospitals in Nicaragua, Wisconsin's "sister state," from Feb. 15 to March 10.

The pediatrician also will be teaching University of Wisconsin Medical School students who are taking their fourth year elective during this time.

Dr. Griggs acts as a preceptor in Nicaragua similar to the program in Wisconsin, but also he shares in the learning opportunities along with the students.

The University of Wisconsin is encouraging other physicians to become interested in such an experience. Ned Wallace, MD of the Department of Pediatrics, who is coordinator for the program, indicated that such an experience would provide significant assistance to the physicians now working at the hospitals by permitting them—because of available free time—to concentrate on administrative and planning aspects of their work. He further stated that the medical school also would benefit from the clinical assistance in teaching of the U. S. physicians.

Dr. Wallace said that there will be an article in the March 1971 issue of READER'S DIGEST about U. S. physicians who volunteer their time and talents to help in hospitals overseas. Development of this article led to discussions which resulted in the Reader's Digest Foundation endowing a program that will permit 50 medical students each year to work in overseas mission hospitals, Dr. Wallace added.

A plea for more volunteer physicians appears in the "Letters" section of this issue.

Dr. Meisinger Heads Fond du Lac Society

New officers of the Fond du Lac County Medical Society for the year 1971 are as follows: president, George F. Meisinger, MD,* Fond du Lac; vice-president, David L. Lawrence, MD,* Fond du Lac; secretary, Joseph C. Devine, Jr., MD,* Fond du Lac; and treasurer, E. Howard Theis, MD,* Fond du Lac.

Nels Alfred Hill, MD*

. . . Madison, recently was honored at a surprise testimonial dinner given in his honor. Doctor Hill recently announced his retirement from private practice. He is a graduate of the Harvard University Medical School and former president of the State Medical Society of Wisconsin. He has practiced in Madison for more than 30 years, has been chief of staff at Madison General Hospital, and was an instructor in clinical medicine at the University of Wisconsin Medical School. He plans to continue his position as medical director for the Wisconsin Life Insurance Co. and as a part-time medical consultant for the Social Security Administration in Madison.

O. B. Beardsley, MD

. . . formerly of Silver Springs, Md., has joined the staff of the Schiek Clinic in Rhinelander. Doctor Beardsley received his medical training at Loma Linda University, Loma Linda, Calif., and has been in practice for a number of years in Maryland.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
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Dr. Mackman

Dr. Miller

Charles H. Miller, III, MD

. . . recently became associated with the medical staff of the Gundersen Clinic, Ltd. and La Crosse Lutheran Hospital in the department of surgery. Doctor Miller attended the United States Naval Academy and obtained his BS degree in 1954, after which he spent four years of subsequent service in the Navy, and was stationed in Washington, D.C. and Japan. He graduated from the University of Wisconsin Medical School in 1962 and served his internship at Madison General Hospital. Doctor Miller was in private practice at Markesan and Portage before taking a residency in general surgery at Madison General Hospital and Hennepin County General Hospital, Minneapolis, Minn.

Sanford Mackman, MD*

. . . has joined the department of surgery at the Jackson Clinic, Madison. Before joining the clinic, Doctor Mackman was an associate professor of surgery and clinical oncology at the University of Wisconsin Medical School.

A native of Milwaukee, he received his BS and MD degrees from the University of Wisconsin. He served an internship at the University of Minnesota in 1960, and after serving a residency in general surgery at the University of Wisconsin, he joined the UW staff in 1964. For the past seven years, he has taught general surgery and engaged in research in cancer surgery, including the "second-look operation" for patients with cancer of the colon, and is also interested in breast diseases. He is certified by the American Board of Surgery.

Christian Medical Society Offers "Working Vacation"

Physicians interested in a two-week "working vacation" abroad are being sought by the Christian Medical Society, a nationwide society of physicians, surgeons, and dentists of all denominations, but especially the Evangelical churches.

During the past few years the Society has developed the idea of Medical Group Missions whereby a team of doctors and nurses spends two weeks in a foreign country administering clinical care and performing surgery.

F. J. Cerny, MD of Fond du Lac, a Mission participant, stated that through this concentrated effort, physicians can arrange to be away from their offices for the short time and yet as a team do a considerable amount of work.

There will be ten Medical Group Missions this year. The Missions will leave from Miami for Honduras April 14–28; Dominican Republic, April 3–10 and June 1–8; and Haiti, June 8–15.

All expenses are paid by the physicians, and these are considered a donation to the Christian Medical Society, enabling a tax deduction, Dr. Cerny said.

Many of the Society's members are missionaries, and short-term missionary work is encouraged. The Society collects medicine from manufacturers as well as samples, and sends the medicine to various missions upon request. Glasses are also collected and sent for the eye projects.

Anyone wishing to participate in one of the Missions, should contact the Christian Medical Society, 1122 Westgate, Oak Park, Ill. 60301.

Search Starts for UW Health Sciences Leader

A 10-member search and screen committee has been appointed by UW Chancellor Edwin Young for the purpose of recommending candidates for the new position of vice-chancellor for health sciences at the University of Wisconsin.

Henry C. Pitot, MD,* pathology, was named chairman of the committee. Members are: Louise C. Smith, assistant dean of the School of Nursing; Donald J. McCarty, dean of the School of Education; Daniel Leicht, a medical student from Racine;

Charles J. Sih, PhD, pharmacy; James D. Whiffen, MD, surgery; Marc F. Hansen, MD,* pediatrics and family medicine; Robert M. Benjamin, PhD, neurophysiology and physiology; Archie A. MacKinney, MD, hematology; and Andrew B. Crummy, MD,* radiology.

Hector F. DeLuca, PhD will be an ex officio member representing the faculty University Committee.

Major reorganization of the medical center, to be renamed the University Center for Health Sciences, will probably begin when the new vice-chancellor is named.

Dr. Marvin Nelson Heads Racine County Society

Marvin W. Nelson, MD* has succeeded Charles Christenson, MD,* as president of the Racine County Medical Society for 1971. Other officers installed at the December meeting are Raymond E. Skupniewicz, MD,* president-elect; Ernest L. MacVicar, MD,* secretary; and Myron Schuster, MD,* treasurer. Members of the board elected at large are Marvin G. Parker, MD* and Brian T. Coffey, MD.* All are from Racine.

Milwaukee Academy of Medicine Met in January

Kenneth H. Cooper, MD, director of the Aerospace Medical Laboratory, USAF, Medical Center, Lackland AFB, Tex., was the featured speaker at the 85th annual dinner meeting of the Milwaukee Academy of Medicine held in January. He spoke on "Testing and Developing Cardiovascular Fitness."

The following officers were installed for 1971: Paul G. LaBissoniere, MD,* Milwaukee, president; Wayne J. Boulanger, MD,* Milwaukee, president-elect; Harold F. Hardman, MD,* Milwaukee, vice-president; Donald A. Roth, MD,* Brookfield, secretary; Donald P. Babbitt, MD,* Milwaukee, treasurer; Sanford R. Mallin, MD,* Milwaukee, librarian; and Sherwood W. Gorens, MD,* Milwaukee, chairman of the membership committee.

River Pines San. to Become Nursing Home

River Pines Sanatorium, Whiting, has been sold by the Sisters of St. Joseph and will become a nursing home. Harold Howard, general manager of the firm, Mid-American Nursing Homes, Inc., Marshfield, who purchased the home, said construction of a 100-bed patient wing will begin this spring with occupancy late this year.

The sisters of St. Joseph have owned River Pines and operated it as a tuberculosis hospital for 33 years. Mr. Howard said the Stevens Point–Whiting area, where River Pines is located, is the ideal location for a nursing home as the only other one in the area is the Portage County Home, and it gives first preference to welfare patients.

Henry Anderson, MD,* River Pines and Madison, has been the medical director at River Pines since 1941, and has for the past three years also been chief medical consultant in Wisconsin for the Bureau of Social Security Disability Insurance.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JANUARY 1971

5 Madison General Hospital Surgical Staff
5 Madison Urological Society
5 Madison Anesthesiology Society
5 Dane County Medical Society Board of Trustees
5 Dane County Medical Society Public Relations Committee
6 Board of Trustees, SMS Realty Corporation
8 SMS Ad Hoc Committee on Medical Practice Act
9 Preceptors, Faculty and Junior Students, University of Wisconsin Medical School
9 Board of Directors, Nelson Muffler Corporation
10 SMS Employee Open House
11 Dane County Medical Society Utilization Review Plan
12 State Medical Examining Board Licensing Exams
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14 Cancer Study Committee, Wisconsin Regional Medical Program
17 SMS Division on Nervous and Mental Diseases (Green Bay)
18 Dane County Medical Society Insurance Advisory Committee
21 Nursing Committee, Wisconsin Regional Medical Program
21 Executive Committee, SMS Commission on Medical Care Plans
27 SMS Commission on Safe Transportation
27 Areawide Health Planning Council
29 Wisconsin Association of Clinic Managers

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Wood County Society Elects Officers

At the December 10 meeting of the Wood County Medical Society the following officers were elected: T. J. Rice, MD,* Marshfield, president; R. L. Johnson, MD,* Wisconsin Rapids, vice-president; and Francis Kruse, Jr, MD,* Marshfield, secretary.

Delegates are: MDs R. F. Lewis,* Marshfield, and E. C. Glenn,* Port Edwards. Their alternates are: MDs N. A. Moffet,* Marshfield, and A. W. Hulme,* Wisconsin Rapids.

Milwaukee's Mt. Sinai Hosp. Changes Name; Expanding

Mount Sinai Medical Center is the new name for what has been known for nearly three quarters of a century as Mount Sinai Hospital, in Milwaukee.

The changing of the name to Mount Sinai Medical Center more accurately reflects both the present and future role that the hospital will play as it serves the modern community, according to Raymond S. Alexander, Executive Vice President of the center.

The center's name change is indicative of the new direction the institution is taking as it launches a several-year, 18 million dollar expansion and renovation program, Mr. Alexander added.

The name change and expansion announcements were made in mid-January by Harry J. Plous, president of Mount Sinai, and Joseph E. Rapkin, chairman of the Board of Trustees.

James J. Balistrieri, MD*

. . . Wauwatosa, recently resigned his position as director of adolescent service at the County Mental Health Center, Milwaukee. Doctor Balistrieri, child psychiatrist, has opened a private treatment center in Milwaukee.

Walter Moritz, MD

. . . and Frank Nichols, MD, Edgerton, recently opened their office for the practice of orthopedic surgery. Doctor Nichols and Doctor Moritz graduated from the Northwestern University Medical School in Evanston, Ill. They are serving the Edgerton, Stoughton, and Fort Atkinson areas.

Manuel N. Roco, MD

. . . Mauston, recently joined the Mauston Clinic and the medical staff of Hess Memorial Hospital. Doctor Roco graduated from the University of Santo Tomas, The Philippines, and interned at St. Barnabas Medical Center in Newark, N. J., followed by four years of residency in general surgery at St. Joseph Hospital, Houston, Tex. Prior to coming to Mauston, he was associated with the Williamson Memorial Hospital, Williamson, W. Va.

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Dr. Herman Dick Heads Sheboygan Society

Herman J. Dick, MD,* a Sheboygan pathologist, in December was reelected to his second one-year term as president of the Sheboygan County Medical Society. He will serve until January 1972 when James S. Jensen, MD* of Cedar Grove will assume the office.

Named as delegates to the State Medical Society were Joseph F. Kovacic, MD* and Roman C. Pauly, MD,* both of Sheboygan.

Alternate delegates for 1971 are Irvin L. Schroeder, MD* and James D. Michael, MD,* both of Sheboygan.

Fred. J. Hofmeister, MD Serves on S.S. HOPE

Frederick J. Hofmeister, MD,* Wauwatosa, recently left on the hospital ship S.S. HOPE bound for Kingston in the West Indies. Doctor Hofmeister is Associate Clinical Professor, Department of Gynecology and Obstetrics at the Medical College of Wisconsin, Milwaukee, and is affiliated with Lutheran, Milwaukee County General, West Allis Memorial, St. Joseph's, and Milwaukee Children's hospitals. He will serve on a two-month tour of service and is one of the more than 100 doctors and other specialized personnel who will serve on a rotating basis during the ship's ten-month mission.

Kenosha County Medical Society Elects Officers

At the December meeting of the Kenosha County Medical Society, the following officers were elected: Frank C. Williams, MD,* president; Walter Rattan, MD,* and Gene F. Armstrong, MD,* delegates; and alternate delegates are Louis Olsman, MD* and Ralph G. Burnett, MD;* and Clifton E. Peterson, MD,* was reelected secretary–treasurer. All are from Kenosha.

Marshfield Clinic Officers Named

Ben R. Lawton, MD* was reelected president of the Marshfield Clinic at its annual meeting in mid-January.

David J. Ottensmeyer, MD* was reelected vice-president. Named secretary was Francis N. Lohrenz, MD,* who succeeds Donald Pederson, MD.* Nelson A. Moffat, MD* was elected treasurer to succeed Dayton Hinke, MD.*

Polk County Medical Society Has Election

Daniel J. Schroeder, Jr., MD,* Amery, was elected president of the Polk County Medical Society at its December meeting. William Fischer, MD,* Frederic, was elected secretary–treasurer, L. O. Simenstad, MD,* Osceola, elected the delegate to the State Medical Society; and Marwood E. Wegner, MD,* St. Croix Falls, alternate delegate.

Named Director of Nurses

Sister Rosemary Hagen, OSF, in mid-January was named director of nurses at St. Joseph Hospital, Beaver Dam. She formerly was an assistant professor at Alverno School of Nursing, Milwaukee.

ANNOUNCING . . . an opportunity for increased benefits through the State Medical Society Life Plan

The State Medical Society of Wisconsin Life Insurance Plan, in successful operation since 1957, has been liberalized a number of times. Now the **coverage available to members has been increased to $50,000** ($75,000 if this amount does not exceed two times the member's annual earnings).

The State Medical Society has arranged for a **limited enrollment** on behalf of its members in order to take advantage of these increased benefits. Details will be sent to members soon by mail.

OUTSTANDING BENEFITS: ■ Individual non-cancellable protection at minimum cost ■ Premium rates guaranteed ■ Premiums based upon age last birthday ■ Accidental Death Benefit at no extra cost ■ Guaranteed conversion privilege at any time, prior to age 70 ■ Ownership is transferable

The State Medical Society continues to recommend this plan as one of the very best available

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CES Foundation Loan Fund for Menominees Available

The CES Foundation of the State Medical Society of Wisconsin recently made available to the residents of Menominee County, financial assistance brought forth from a scholarship and loan fund which was established by a grant from the estate of the late Miss Ruth Coe of Madison. Miss Coe was instrumental in beginning the practical nurses program in the state and served as president of the Wisconsin Nurses Association. The assistance is for Menominee County residents who are now enrolled or plan to enter an educational program in pursuit of a health career such as medicine, nursing, or related technological programs.

CONTRIBUTIONS—CES FOUNDATION December 1970

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for December 1970:

Nonrestricted

Robert B. Murphy, Daniel LaVine, MD	Contributions
State Medical Society Members	Voluntary contributions of 6 MDs
Dr. & Mrs. E. J. Nordby	Memorial: Matt J. Kelzenberg
Dr. & Mrs. E. J. Nordby, Earl R. Thayer, Dr. & Mrs. James C. Fox, Robert B. Murphy	Memorial: Victor E. Ekblad, MD
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State Medical Society	Memorials: A. H. Lamal, MD, H. W. Sargeant, MD, J. A. Pizer, MD, S. D. Rosenkrans, MD, R. A. Rufflo, MD, J. W. Towey, MD (nonmember)

Other Than CESF Projects

State Medical Society Members	Voluntary contribution of 1 MD

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorials: Mr. John L. Doran & Mrs. K. M. Sachtjen

Student Loans

Gustave E. Eck, MD, NMC Projects, Inc.	Contributions

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Brown County Loan Fund

Woman's Auxiliary to Brown County Medical Society	Contribution

Gill Lamp Fund

Donald E. Gill	Contribution

Tormey Memorial Fund

Thomas W. Tormey, Jr., MD	Contribution

Museum of Medical Progress

C. W. Leonard, MD	Contribution

Stanley N. Graven, MD*

. . . Madison, recently was appointed to the American Academy of Pediatric's Committee on the Fetus and Newborn. Doctor Graven is affiliated with the Pediatrics Department at the University of Wisconsin Medical School and is director of the Neonatal Center at St. Mary's Hospital, Madison.

Wallace G. Irwin, MD*

. . . Lodi, recently attended the International College of Surgeons meeting in Las Vegas, Nev., where he was installed as a fellow in the organization. Doctor Irwin is the chief of staff at Divine Savior Hospital, Portage.

William A. Kisken, MD

. . . La Crosse, recently joined the department of surgery at Gundersen Clinic and Lutheran Hospital in La Crosse. Doctor Kisken will be a member of a special department of transplantation surgery which will be opened soon. He received his medical degree from the University of Chicago and interned at Blodgett Hospital in Grand Rapids, Mich. Residency training was taken at the University of Minnesota and at University Hospitals in Madison. Doctor Kisken has been associated with the University of Wisconsin Medical School as an instructor in surgery from 1963–1965, an assistant professor from 1965–1968, and an associate professor since 1968.

Florentino E. Lleva, MD

. . . Arcadia, recently began his practice at the Arcadia Medical Center. A graduate of Manila Central University, The Philippines, he has interned at Norwegian American Hospital, Chicago, and has done residency work at Memorial Hospital, Elmhurst, Ill., Norwegian American Hospital and Lutheran Deaconess Hospital, Chicago. He was on the house staff of Mercy Hospital, Chicago and Christian Hospital, St. Louis, Mo. Doctor Lleva has taken postgraduate training at Loyola University School of Medicine in Chicago.

Sandra W. Gomez, MD*

. . . Milwaukee, recently became a fellow of the American College of Anesthesiologists.

Jose M. Palisoc, Jr., MD

. . . Cudahy, recently joined the staff of the Ackerman Clinic, Cudahy. Doctor Palisoc graduated from the University of Santo Tomas, Manila, The Philippines, interned at Evangelical Deaconess Hospital, Milwaukee, and completed his residency at Deaconess and Mt. Sinai hospitals, Milwaukee.

Kenneth Alan Stormo, MD

. . . Fond du Lac, recently joined the medical staff of St. Agnes Hospital, Fond du Lac. He completed his medical training at the University of Nebraska College of Medicine and served his residency in pathology at Denver General Hospital. Prior to his appointment at St. Agnes, he was pathologist at Brook General Hospital, Ft. Sam Houston, Tex., at which time he became board certified by the American Board of Pathology.

Antonio Jhocson, MD

. . . Beloit, recently became associated with the medical staff of Beloit Clinic, in the department of internal medicine. He came to Beloit from Fresno, Calif. where he was a staff physician at the Veterans Administration Hospital. He received his medical education at the University of Santo Tomas, Manila, The Philippines, and served his internship at the Suburban Hospital, Bethesda, Md., and at St. Charles Hospital, Toledo, Ohio. After his internship, he took a residency in internal medicine with a subspecialty in cardiology with the Fordham–Misericordia Affiliated Hospital, Bronx, N. Y.

Donald M. Luedke, MD*

. . . Brookfield, recently was chosen chief-elect of the medical staff of the Elmbrook Memorial Hospital. Doctor Luedke will take office in January, 1972, succeeding William C. Curtis, MD,* Elm Grove, the present chief of staff.

Sigurd B. Gundersen, Jr., MD*

. . . La Crosse, was elected president of the medical staff of Lutheran Hospital, La Crosse. Other new officers are: Duane W. Taebel, MD,* vice-president; and Rudolph M. Keimowitz, MD,* secretary. □

Health Division Surveys State's Children on Disease Protection

A survey to determine how well protected Wisconsin children are against certain common childhood diseases is being conducted by the State Division of Health, Department of Health and Social Services.

During January, parents of selected children 21 to 24 months of age in 48 of the state's 72 counties received survey forms inquiring whether their child has been protected against eight diseases: diphtheria, whooping cough, tetanus, poliomyelitis, smallpox, red measles (hard measles) and rubella (German measles).

The remainder of the counties will be surveyed next year.

Through surveys such as this, the Division expects to locate areas where children do not have adequate immunization. It could then inform local health departments and doctors so that special programs can be conducted before these children become infected.

Since a simple dose, or series of doses, provides long lasting protection against the effects of these diseases, there is no reason for any of the diseases to be allowed to attack, sicken or kill a child, according to H. Grant Skinner, MD,* Chief of the Communicable Diseases Section.

He said in later questionnaires, a question concerning immunization against mumps will be added.

The Division also released a suggested basic immunization schedule, taken from the recommendations of the Advisory Committee on Immunization Practices, U. S. Public Health Service. The recommendations are reviewed by the committee frequently and updated as new information becomes available.

Dr. Apfelbach Heads Rock Medical Society

The newly elected president of the Rock County Medical Society is G. Leonard Apfelbach, MD* of Janesville.

Allen Tuftee, MD* of Beloit was named vice-president and R. R. Schwaegler, MD* of Beloit was named secretary-treasurer.. □

SUGGESTED BASIC IMMUNIZATION SCHEDULE

Diphtheria, Tetanus, Whooping Cough:

Three doses, each one at 4 to 6 week intervals, usually starting at 2 to 3 months of age.

Booster dose on entrance to elementary school.

Tetanus, Diphtheria:

After a full primary immunization, a booster is recommended once every ten years or after an injury, whichever occurs first.

Poliomyelitis: Oral, Trivalent

Three doses: First dose—6 to 12 weeks of age;
second dose—6 to 8 weeks later;
third dose—8 to 12 months after second dose.

A booster dose should be given on entrance to school.

Smallpox:

Primary vaccination within second year of life.
Revaccination on entrance to school.
Routine vaccination every ten years.

Red Measles (Rubeola):

One dose recommended for all children who have not had the disease.

Rubella (German Measles):

One dose is recommended for all children aged one year to puberty, whether or not they think they have had the disease. Women of child bearing age should be tested. If they are not immune to rubella they should consider immunization.

Mumps:

One immunization is recommended for all persons over one year of age.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF DECEMBER 31, 1970

NEW MEMBERS

Boyer, Stanley W., 30 South Henry St., Madison 53703
Chambers, James D., 1313 Fish Hatchery Rd., Madison 53715
Comin, Donald B., 815 South 10th St., La Crosse 54601
Dunkelberger, Lawrence, 4410 Regent St., Madison 53705
Glasser, James E., 3161 South 35th St., La Crosse 54601
Gunderson, Finn O., 1260 Valley Rd., Appleton 54911
Halbert, Helen E., 1836 South Ave., La Crosse 54601
Krueger, LeRoy A., 808 Third St., Wausau 54401
May, Edwin G., 2501 Main St., Stevens Point 54481
Millar, Iluminado M., 5631 West Lincoln Ave., West Allis 53219
Mockert, Thomas, Jr., 1720 North 8th St., Sheboygan 53081
Morris, William G., 810 Evergreen Court, Rhinelander 54501
Munoz, Rodrigo A., 417 Security Bank Bldg., Sheboygan 53081
Murphy, James E., 3400 Crestview Dr., Appleton 54911
Peterson, Lowell F., 424 East Longview Dr., Appleton 54911
Rodman, Charles A., 1836 South Ave., La Crosse 54601
Schiebler, John C., 2910 Blackhawk Pl., La Crosse 54601
Smalley, John James, 212 South 11th St., La Crosse 54601
Torstenson, Ordean L., 2508 Waunona Way, Madison 53713
Ward, Richard H., 1602 North Meade St., Appleton 54911

CHANGE OF ADDRESS within a city

Beglinger, Harold F., 2280 East Valley, #121, Escandido, Calif. 92025
Hamacher, John E., 20 South Park St., Madison 53715
Krohn, Eugene, 610 West Adams, Black River Falls 54615
Lass, Thomas E., 2425 North 124th St., Milwaukee 53226
Leverenz, Richard L., 5842 North Shore Dr., Milwaukee 53217
Love, Robert G., P. O. Box 26, Prairie du Chien 53821
Maurer, William J., 1311 Lincoln Ave., Marshfield 54449
Molina, Rodolfo, P. O. Box 512, Beaver Dam 53916
Pratt, Mary V., 43 Gray St., Boston, Mass. 02116
Quisling, Sverre, 1240 Sherman Ave., Madison 53703
Rauch, William A., 2002 Wollmer St., Manitowoc 54220
Solochek, Sheldon M., 5035 North Sheffield Ave., Milwaukee 53217
Steffan, Lloyd J., 1000 Eastern Ave., Plymouth 53073
Thurow, Roland M., 610 West Adams, Black River Falls 54615
Walton, William B., 5016 West Burleigh St., Milwaukee 53210
Wegner, Gene P., 4815 Tonyawatha Trail, Madison 53716
Wong, James R. P., P. O. Box 350, Prairie du Chien 53821
Wohlwend, Edward B., 130 Warren St., Beaver Dam 53916

CHANGE OF ADDRESS from city to city

Cossman, Madison, to 427 North Hillside, Wichita, Kan. 67214
Danocup, Robert J., Milwaukee, to Route 5, Box 180, 2208 Easy St., Beloit 53511
Graham, Albert P., Neenah, to 5100 Dupont Blvd., Apt. 6N, Fort Lauderdale, Fla. 33308
Janes, Donald R., Wausau, to 920 West 47th St., Kansas City, Mo. 64112
Leh, Patrick S. S., Milwaukee, to 126 South Main St., Seymour City 54165
Lelonek, Robert D., Waukesha, to 1770—44th St., Rock Island, Ill. 61201
Parnell, Francis W., Jr., San Rafael, Calif., to DA, Letterman General Hospital, Presidio of San Francisco, Calif. 94129
Pulido, Ernesto D., Rhinelander, to 615 South Mill, Fergus Falls, Minn. 56537
Quisling, Rolf A., Madison, to 1302 Capitol View Rd., Middleton 53562
Schutte, Albert G., Milwaukee, to Route 1, Box 21A, Mukwonago 53149
Smith, Alvin L., El Sereno, Calif., to 18661 Via Palatino, Irvine, Calif. 92664

DEATHS

Werra, Martin J., Waukesha County, Nov. 20, 1970
Hirschboeck, John G., Door–Kewaunee County, Nov. 22, 1970
Dunn, Cornelius F., Milwaukee County, Nov. 25, 1970
Towey, John W., non-member, Nov. 28, 1970
Ekblad, Victor E., Douglas County, Nov. 30, 1970
Rolfs, Theodore H., Milwaukee County, Dec. 18, 1970
Dean, George W., Milwaukee County, Dec. 21, 1970
Bentley, John E., non-member, Dec. 22, 1970
Sieb, Louis H., Brown County, Dec. 23, 1970
Lindsay, William T., Dane County, Dec. 25, 1970 □

OBITUARIES

Martin J. Werra, MD, 74, Waukesha, died Nov. 20, 1970, in Waukesha.

Born on March 31, 1896, in Manitowoc, Doctor Werra graduated from the Marquette University School of Medicine in the middle 1920s. For many years, he was the City of Waukesha's physician and from 1943 to 1944, he was chief of staff of the Waukesha Memorial Hospital.

He was a member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Elsie; two daughters, Mrs. Edward (Rosemary) Chezch, Pewaukee, and Mrs. Peter (Barbara) Curran, North Haven, Conn.; and two sons, Martin J., Milwaukee, and Dr. Robert, Ukiah, Calif.

John G. Hirschboeck, MD, 83, Forestville physician for 54 years, died Nov. 22, 1970, in Forestville.

Born on April 19, 1887, in Barton (now part of West Bend), Doctor Hirschboeck graduated from the Marquette University School of Medicine in 1913 and served his internship at Milwaukee County General Hospital and St. Joseph Hospital, Milwaukee. He was the house physician at Johnston Emergency Hospital, Milwaukee, for two years, and served on the staffs of St. Vincent Hospital, Green Bay, Door County Memorial Hospital, Sturgeon Bay, and Algoma Memorial Hospital, Algoma.

His Forestville practice began 54 years ago, on Sept. 16, 1916. In the early twenties, Doctor Hirschboeck and a Maplewood garageman, John Kreft, designed and made what they called the first snowmobile. They welded two wheels together on each side of the back of the Model T, put truck chains around them, and used regular farm sleigh runners for the front.

He was a member of the Door–Kewaunee County Medical Society, State Medical Society of Wisconsin, and American Medical Association for more than 50 years.

Surviving are his widow, Gertrude; a daughter, Mrs. Robert (Jeanette) Coughlan, and a son, George, both of Mankato, Minn.; and four stepchildren, Miss Connie Stroh, Shreveport, La., Earl Stroh, Sturgeon Bay, Robert Stroh, Battle Creek, Mich., and Mrs. Roderick (Marian) Schlise, Sturgeon Bay.

Cornelius F. Dunn, MD, 66, Milwaukee, died Nov. 25, 1970, in Milwaukee.

Born on Dec. 10, 1903, in Milwaukee, he graduated from Marquette University School of Medicine in 1931

and served his internship and residency at Milwaukee County General Hospital. Doctor Dunn was the medical director and assistant professor of internal medicine of the Medical College of Wisconsin. He had been the health center director at St. Camillus, Wauwatosa, since 1940 and for the last 30 years had taught and conducted a private practice. He was also a staff member at St. Joseph and Milwaukee County General Hospitals.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Florence; four sons, Dr. Michael J., Burlington, Vt., Cornelius P. and James F., San Francisco, and Kevin B., Milwaukee; and a daughter, Mrs. Eileen Gaynor, Berkeley, Calif.

John W. Towey, MD, 79, Middleton, died Nov. 28, 1970, in Madison.

Born in Stillwater, Minn., Doctor Towey graduated from Northwestern University Medical School in 1914 and served in the Army Medical Corps in World War I. From 1922 until his retirement in 1960, Doctor Towey was medical superintendent of Pinecrest Sanatorium, Powers, Mich., and from 1945 to 1960 was an area consultant to the Veterans Administration. He was one of a group that organized the Pembine Conference, concerned with pulmonary disease diagnosis and treatment, which has met annually since 1942.

He has been honored by several medical groups during his career. He received the bronze medal of the American Medical Association in 1933, the Dearholt Medal of the Mississippi Valley Tuberculosis Conference in 1957, and the Bruce Douglas Medal of the Michigan Thoracic Society in 1958. He was elected an honorary member of the American Thoracic Society in 1967, after serving as its vice-president in 1957.

In 1928, Doctor Towey was vice-president of the American Assn. of Railway Surgeons, in 1955, was president of the Mississippi Valley Tuberculosis Conference. He was affiliated with the American College of Physicians and the American Society of Internal Medicine and was a member of the American Medical Association.

Surviving are his widow, Rega; two daughters, Mary R., Minneapolis; and Mrs. Harland Parks, Middleton; and a son, John J., Edina, Minn.

Victor E. Ekblad, MD, 84, Superior, died Nov. 30, 1970, in Superior.

Born on Oct. 10, 1886, in Randolph, Kansas, Doctor Ekblad graduated from the University of Kansas Medical School in 1909, and served his internship at Christ Hospital in Topeka, Kan.

Doctor Ekblad served on the medical staff of St. Mary's Hospital in Superior for 50 years, and was a past president of the Soo Line Railroad and the Great Northern Surgeons Associations. He was a councilor from the 11th district of the State Medical Society from 1943–1966 and was a member of the "50 year" Club of the Society.

He also was a member of the International College of Surgeons, American Medical Association, and a past president of Douglas County Medical Society.

Surviving is his widow, Elda, of Superior.

Theodore H. Rolfs, MD, 94, died Dec. 18, 1970, in Waukesha.

Born on July 25, 1877, in Milwaukee, he graduated from the University of Illinois Medical School in 1901. He served his internship at St. Mary's Hospital, Milwaukee, and was its first intern from 1901–1902. He became a member of the staff in 1906 and was the chief of staff in 1931. Doctor Rolfs was a charter member of the American and Wisconsin Academies of General Practice.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are three sons, T. W., San Francisco, Calif.; David J., Stanford, Calif.; and Robert J., Waterford, Wis.; and four daughters, Mrs. Wm. (Marie) Retzlaff, Stanford, Calif.; Mrs. Charles (Jane) Eichenberger, Mrs. John (Pattie) Manning, Des Plaines, Ill.; and Mrs. Robert (Peggy) Brumsted, Vienna, Va.

George Walter Dean, MD, 60, Milwaukee internist and allergist for 28 years, died Dec. 21, 1970, in Milwaukee.

Born on Oct. 9, 1910, in Madison, Doctor Dean graduated from the University of Wisconsin Medical School in 1934 and served his internship at Philadelphia Graduate Hospital in Pennsylvania. His residency was taken at the Wisconsin General Hospital in Madison.

Doctor Dean served on the medical staff of the Milwaukee Children's Hospital, Columbia Hospital, St. Mary's Hospital, and Milwaukee County General Hospital. He also served as clinical instructor at the Medical College of Wisconsin. He was a Fellow of the American Academy of Allergy and the American College of Physicians. He was a member of the Commission on Health Information of the State Medical Society of Wisconsin, the Wisconsin Society of Internal Medicine, and the American College of Allergists.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Dorothy, Milwaukee.

William Thomas Lindsay, MD, 90, Madison, died Dec. 25, 1970, in Madison.

Born on Feb. 14, 1880, in Dane County, Doctor Lindsay graduated from the University of Illinois Medical School in 1905 and served his internship at the Madison Sanitarium. He practiced in South Dakota for a few years and returned to Madison in 1912. He had been in continuous practice until his retirement in 1965.

Doctor Lindsay was a member of the medical staff of Madison General Hospital and served as chief of staff for two terms. He was a long time gardening enthusiast, and was the founder and former president of the City Farmers Club.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are two daughters, Mrs. Glenn Curry, Madison, and Mrs. Otis Crary, Dane. □

NEW POSTAGE STAMP SALUTES BLOOD DONORS

A new 6-cent postage stamp will be issued March 12 in New York City in conjunction with the International Philatelic Exhibition, it was announced recently by Postmaster General Winton M. Blount.

The stamp has been designed to salute blood donors and to urge increased participation in this vital program. Its theme is: "Giving Blood Saves Lives."

Collectors desiring first day cancellations may submit orders to the Postmaster, New York, New York 10001, plainly indicating the full name and address, INCLUDING ZIP CODE, with remittance to cover the cost which is 6¢ each. The outside envelope to the Postmaster should be endorsed "First Day Covers 6¢ Blood Donor Postage Stamp." Orders must be postmarked no later than March 12, 1971.

the wisconsin medical journal

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STATE MEDICAL SOCIETY OF WISCONSIN

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Apr. 20: Monthly meeting of Milwaukee Academy of Medicine, University Club of Milwaukee. Guest speaker: Dr. Morton D. Bogdonoff, University of Illinois, "Planning to Avoid Obsolescence."

May 3–5: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 10–12: Annual Meeting, State Medical Society of Wisconsin, Hotel Sheraton–Schroeder and Pfister Hotel, Milwaukee.

May 11–12: Wisconsin Clinic Managers Meeting, Pfister Hotel, Milwaukee.

May 24–26: Annual scientific sessions of The Wisconsin Heart Association—"An Appraisal of Coronary Surgery 1971." Milwaukee Expo and Red Carpet Inn, Milwaukee. Program Director: H. David Friedberg, MD.

Aug. 5–28: Scandinavian/Russian Holiday, Wisconsin Alumni Association. Info: Wisconsin Alumni Tours, 650 N. Lake St., Madison, Wis. 53706.

Sept. 22: Sixth annual Adolf Gundersen Symposium for Physicians—"Understanding Arrhythmias." Co-sponsored by the Wisconsin Heart Association and the Adolf Gundersen Foundation. Valhalla Hall, Wisconsin State University, La Crosse.

Oct. 17–23: Wisconsin Work Week of Health.

1971 NEIGHBORING STATES

Apr. 19–21: *Clinical Pharmacology with Emphasis on Newer Drugs.* American College of Physicians, The University of Michigan Medical Center, Ann Arbor. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

Apr. 23–24: 28th annual Meeting, American Geriatrics Society, Ambassador Hotel, Chicago. Info: Edward Henderson, MD, Exec. Dir., AGS, 10 Columbus Circle, New York, N.Y. 10019.

Apr. 26–28: Great Lakes Health Congress, Health Industries Association/Mid-America Nursing Home Association/Tri-State Hospital Assembly, McCormick Place-on-the-Lake, Chicago. Info: Great Lakes Health Congress, c/o Tri-State Hospital Assembly, 400 North Michigan Ave., Chicago, Ill. 60611; tel. (312) 321–0317.

May 16–19: 131st Annual Convention, Illinois State Medical Society, Arlington Park Towers, Arlington Heights, Ill.

May 17–19: Annual Convention, Minnesota State Medical–Association, St. Paul Hilton Hotel, St. Paul, Minn.

Summer: *1971 North Michigan Summer Course,* University of Michigan Department of Postgraduate Medicine, Traverse City at Shanty Creek Lodge, Bellaire. Info: U–M Dept of PG Med, Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48104.

Sept. 13.–15: *Clinical Electroencephalography.* American Electroencelphalographic Society, in Minneapolis, Minn. Info: Donald W. Klass, MD, EEG Course Dir., Mayo Clinic, Rochester, Minn. 55901.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

1971 OTHERS

Mar. 31–Apr. 1: *Updating Neurology.* Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland, Ohio 44106.

Apr. 5–6: *Second Annual Sports Medicine Symposium.* Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland, Ohio 44106.

Apr. 19–21: Annual spring session, American Academy of Pediatrics, St. Louis, Mo.

Apr. 19–22: American Industrial Health Conference, The Marriott, Atlanta, Ga.

Apr. 21–23: "Management and Care of Respiratory Insufficiency," University of Colorado School of Medicine, Denver.

Apr. 26–29: *Eighth Annual Reserve Forces Medical Symposium.* Air National Guard and Air Force Reserve, Houston, Tex.

Apr. 29–May 1: *Clinical Dermatology.* University of Colorado School of Medicine, Denver.

Apr. 30–May 20: Spring Postgraduate Medical Seminar Cruise to the Mediterranean, Department of Postgraduate Medicine of Albany Medical College, New York.

May 1–2: 19th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, Civic Auditorium, San Francisco, Calif. Info: Donald F. Richardson, 79 West Monroe St., Chicago, Ill. 60603.

May 7–9: Medical Legal Conference, American College of Legal Medicine, Royal Orleans Hotel, New Orleans, La. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

May 10–12: Annual Meeting, American College of Sports Medicine, Toronto, Canada. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706; tel.: area code 608/262–3632)

May 17–19: Second National Conference on Breast Cancer, American Cancer Society, Century Plaza Hotel, Los Angeles, Calif.; info: Esther Kelley, Professional Education, ACS, Inc., 219 East 42nd St., New York, N.Y. 10017.

May 19–21: Annual "Topics in Internal Medicine" course, University of Florida College of Medicine, Gainesville.

May 24–26: Pharmaceutical Manufacturers Association, annual convention, White Sulphur Springs, W. Va.

May 24–28: Fifth Postgraduate Course in the "Care of Spinal Cord Injury Patients," Veterans Administration Hospital, Long Beach, Calif. Applications to: Dr. Erich G. Krueger, Director of Spinal Cord Injury Service (127), VA Central Office, 810 Vermont Ave., N.W., Washington, D.C. 20420, before April 1.

June 7–11: Annual convention, Catholic Hospital Association, Atlantic City, N.J.

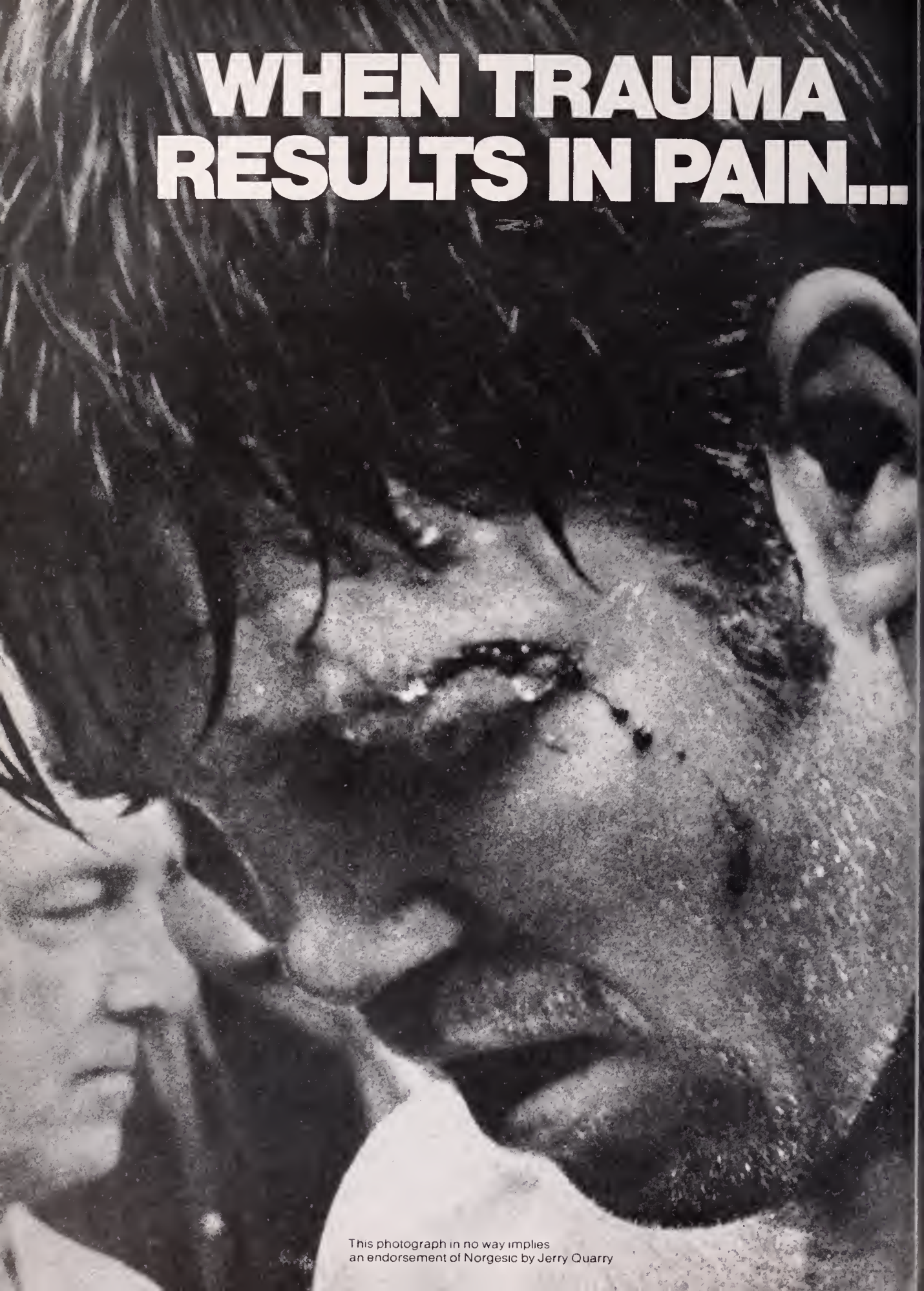
June 7–11: *Internal Medicine: Clinical Problems, 1971.* American College of Physicians, University of Cincinnati Medical Center, Ohio. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

June 21–26: Annual General Practice Review, University of Colorado School of Medicine, Estes Park.

June 28–July 2: *Advances in Internal Medicine: Recent Perspectives.* American College of Physicians, University of Alberta Medical School at Edmonton, and the University of Calgary Medical School, to be presented at the Banff School of Fine Arts, Banff, Alberta, Canada. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

July 5–8: *Ophthalmology.* University of Colorado School of Medicine, Colorado Springs.

July 11–14: *Pediatrics.* University of Colorado School of Medicine, Aspen.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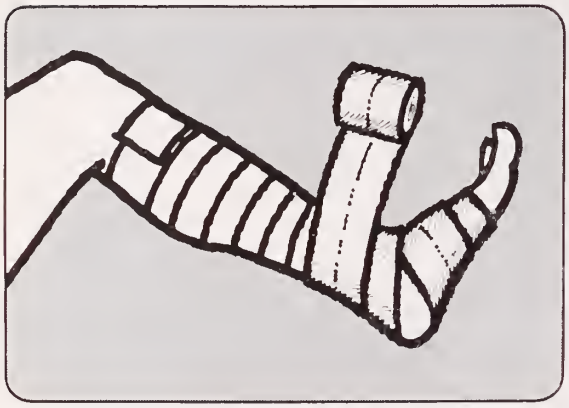

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July 20–24: *Internal Medicine.* University of Colorado School of Medicine, Estes Park.

July 26–29: *Recent Advances in Rheumatic Diseases.* American College of Physicians and University of Colorado School of Medicine, Estes Park.

Sept. 27–Oct. 1: *Hospital Medical Staff Conference,* University of Colorado School of Medicine, Estes Park.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Oct. 5–7: *18th Spinal Cord Injury Conference.* Joint meeting of Veterans Administration Department of Medicine and Surgery and International Medical Society of Paraplegia, Children's Hospital Medical Center, Boston, Mass.

Nov. 15–18: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, 307 No. Charter St., Madison, Wis. 53715)

1971 AMA

June 20–24: AMA Annual Session, Atlantic City, N.J.

Aug. 30–31: Congress on Occupational Health, Jackson Lake Lodge, Wyoming.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 3: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Biltmore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New York N.Y. 10017.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

For listing of other meetings see the **Journal of the American Medical Association.**

1971 ANNUAL MEETING

Scientific Program

IN CONDENSED FORM

State Medical Society of Wisconsin

MAY 10-12

MILWAUKEE

HOTEL SHERATON–SCHROEDER

PFISTER HOTEL AND TOWER

THE COMMISSION ON SCIENTIFIC MEDICINE is pleased to invite you to attend the 1971 Annual Meeting of the State Medical Society of Wisconsin, in Milwaukee, May 10 through 12. Hotel Sheraton–Schroeder and Pfister Hotel and Tower will be the two meeting sites. (The Milwaukee Auditorium will not be used this year.)

This year's program includes a new feature. Each morning, May 10–11–12, will be devoted to a Plenary Session which all physicians are urged to attend. Some topic, meaningful to all, will be presented each morning from 9:30 until 12:00 noon. These programs have been arranged by the Section on Internal Medicine—Monday, May 10; the Section on General Practice—Tuesday, May 11; and the Section on Surgery—Wednesday, May 12. Programs arranged by other Sections will be presented each afternoon of the three-day meeting.

All scientific programs, technical exhibits, and scientific exhibits will be located at the Hotel Sheraton–Schroeder.

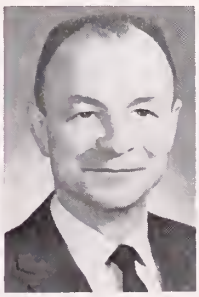
All scientific luncheons will be held at the Hotel Sheraton–Schroeder. There will be no Annual Dinner.

The Presidential Reception will be held at the Pfister Hotel and Tower on Tuesday evening from 6:00 to 8:00 pm. Everyone is urged to attend.

Exhibits—25 scientific and 60 technical—will be located at the Hotel Sheraton–Schroeder. Considerable effort has been expended in changing this location from the Milwaukee Auditorium, where the exhibits have been located for a number of years, to the Hotel S–S. It is the Commission's hope that the new location will provide a more suitable environment for physicians and create a greater interest in the exhibits.

A condensed version of the scientific program as scheduled on March 1 appears on the following pages. Further program details also will appear in the April issue.

Anthony V. Pisciatta, MD
Chairman, General Program



Gerald J. Derus, MD
Chairman, Scientific Exhibits

Ben R. Lawton, MD
Chairman, Commission on Scientific Medicine

Timetable

Note: S–S: Sheraton–Schroeder Hotel
Pfister: The Pfister Hotel and Tower

SATURDAY, MAY 8

Noon

12:00 Council Executive Committee Luncheon: Empire Room (7th Fl.) Pfister

p.m.

2:00 Council Executive Committee Meeting: Empire Room (7th Fl.) Pfister

5:30 Council Dinner: Cafe Rouge (Lobby Fl.) Pfister

7:00 Council Meeting: Cafe Rouge (Lobby Fl.) Pfister

SUNDAY, MAY 9

a.m.

8:00 Installation of Exhibits: Fifth Floor & Empire Room (Lobby Fl.) S–S

10:30 Section Delegates Caucus: Richard–Charles Rooms (7th Fl.) Pfister

p.m.

1:00 House of Delegates Registration, Grand Foyer (7th Fl.) Pfister

2:00 House of Delegates, First Session: Grand Ballroom East & Center (7th Fl.) Pfister

5:30 House of Delegates Buffet Supper: Imperial Ballroom (7th Fl.) Pfister

7:30 Reference Committee—Resalutions and Amendments: Grand Ballroom East & Center (7th Fl.) Pfister; Reports of Officers: Henry VIII Room (7th Fl.) Pfister; Reports of Standing Committees: Louis XIV Room (7th Fl.) Pfister; and Finances: Richard–Charles Rooms (7th Fl.) Pfister

MONDAY, MAY 10

a.m.

7:30 Catholic Physicians Guild Breakfast: English Room (5th Fl.) S–S

8:00 Registration (4th Fl., S–S) and opening of exhibits: Fifth Fl. & Empire Room (Lobby Fl.) S–S

9:30 Scientific Program—*Plenary Session*: "The Spleen, Organ of Mystery: Clinical Concepts and Management": Loraine Room (Lobby Fl.) S–S

p.m.

12:15 Scientific Luncheons: Fourth Floor, S–S

1:30 Auxiliary Registration: King's Row (7th Fl.) Pfister

2:00 Scientific Program: Hotel S–S

Internal Medicine—Loraine Rm. (Lobby Fl.) S–S
Pathology—English Room (5th Fl.) S–S
Radiology—Pere–Marquette Room (5th Fl.) S–S

3:00 Nominating Committee: King's Row (7th Fl.) Pfister

3:00 Auxiliary Board Meeting: Henry VIII Rm. (7th Fl.) Pfister

4:00 Board of Directors, Wisconsin Academy of General Practice: Roosevelt–Kennedy Rms. (7th Fl.)

6:00 House of Delegates Registration: Grand Foyer (7th Fl.) Pfister

6:00 Auxiliary Dinner: Cafe Rouge (Lobby Fl.) Pfister

6:00 Radiology Dinner: Milwaukee Yacht Club (members only)

7:00 House of Delegates, Second Sessian: Grand Ballroom East & Center (7th Fl.) Pfister

continued

TIMETABLE—*continued*

TUESDAY, MAY 11

a.m.

7:30 PACE Breakfast: Imperial Ballroom (7th Fl.) Pfister

7:30 House of Delegates Registration: Grand Foyer (7th Fl.) Pfister

8:30 House of Delegates, Third Session: Grand Ballroom East & Center (7th Fl.) Pfister

8:30 Registration (4th Fl., S–S) and Exhibits: Fifth Floor & Empire Room (Lobby Fl.) S–S

9:30 Scientific Program—*Plenary Session*: "Problems for Everyone": Loraine Room (Lobby Fl.) S–S

9:30 Auxiliary Business Meeting: King's Row (7th Fl.) Pfister

10:30 Council Meeting: Roosevelt–Kennedy Rooms (7th Fl.) Pfister

p.m.

12:00 Clinic Managers Luncheon: Grand Ballroom West (7th Fl.) Pfister

12:15 Scientific Luncheons: Fourth Floor, S–S

12:30 Council Luncheon: Taft–McKinley Rooms (7th Fl.) Pfister

12:30 Auxiliary Luncheon: Imperial Ballroom (7th Fl.) Pfister

2:00 Scientific Programs: Hotel S–S

Family Medicine—Loraine Rm. (Lobby Fl.) S–S
Allergy—English Room (5th Fl.) S–S
Dermatology—Room 504 (5th Fl.) S–S
Neurology—Pere–Marquette Rm. (5th Fl.) S–S
Resident–Intern Papers—Rm. 503 (5th Fl.) S–S

6:00 President's Reception: Imperial Ballroom (7th Fl.) Pfister

8:00 Marquette Alumni Dinner: Milwaukee Athletic Club

WEDNESDAY, MAY 12

a.m.

8:30 Registration (4th Fl., S–S) and Exhibits: Fifth Floor & Empire Room (Lobby Fl.) S–S

8:30 Auxiliary Registration: King's Row (7th Fl.) Pfister

9:30 Scientific Program—*Plenary Session*: "Pulmonary Care as Viewed by the Internist, Surgeon, Anesthesiologist, and Pathologist," Loraine Room (Lobby Fl.) S–S

9:30 Auxiliary Business Meeting, King's Row (7th Fl.) Pfister

noon

12:00 Past Presidents Luncheon: Richard–Charles Rooms (7th Fl.) Pfister

p.m.

12:15 Scientific Luncheons: Fourth Floor, S–S

12:30 Auxiliary Luncheon, Grand Ballroom East (7th Fl.) Pfister

2:00 Scientific Programs: Hotel S–S

Anesthesiology—Pere–Marq. Room (5th Fl.) S–S
Ophthalmology—English Room (5th Fl.) S–S
Otolaryngology—Room 503 (5th Fl.) S–S
Orthopedics—Room 504 (5th Fl.) S–S
Surgery—Loraine Room (Lobby Fl.) S–S

2:30 Auxiliary Board Meeting: King's Row (7th Fl.) Pfister

3:45 Closing of Exhibits: Fifth Floor & Empire Room (Lobby Fl.) S–S

6:00 Milwaukee Ophthalmological Society Dinner: University Club

6:30 Wisconsin Orthopedic Society: University Club

6:30 Wisconsin Surgical Society: Performing Arts Center

OUT-OF-STATE GUEST SPEAKERS and SCHEDULES

FREDERIC C. BARTTER, MD
Chief, Endocrinology Branch, National Heart and Lung Institute, Bethesda, Md.

TUESDAY, MAY 11: 11:00 am—*Osteoporosis, Everybody's Problem;* 12:15 pm—*Chronobiology in Health and Disease*

ARNOLD P. FRIEDMAN, MD
Clinical Professor of Neurology, College of Physicians and Surgeons, Columbia University, New York City

TUESDAY, MAY 11: 3:30 pm—*An Overview of Chronic Recurring Headache;* 12:15 pm—*The Effects of Headache on History*

HARRY S. JACOB, MD
Chief, Section of Hematology and Professor of Medicine, University of Minnesota Medical School, Minneapolis, Minn.

MONDAY, MAY 10: 10:10 am—*Hereditary Spherocytosis, Mechanisms and Treatment;* 12:15 pm—*The Diagnosis of Hemolytic Anemias*

SIMON KRAMER, MD
Professor and Chairman, Department of Radiation Therapy, Thomas Jefferson University Hospital, Philadelphia, Pa.

MONDAY, MAY 10: 2:00 pm—*Radiotherapy of Breast Carcinoma;* 12:15 pm—*Current Concepts in the Treatment of Breast Cancer*

JAMES H. MATTHEWS, MD
Professor of Anesthesiology, University of Minnesota Medical School, Minneapolis, Minn.

WEDNESDAY, MAY 12: 2:00 pm—*Myths to Abandon;* 12:15 pm—*Anesthesia Specialty Board Requirements: Questions and Answers*

JOSEPH H. OGURA, MD
Professor and Head, Department of Otolaryngology, Washington University School of Medicine, St. Louis, Mo.

WEDNESDAY, MAY 12: 2:00 pm—*Reconstruction Head and Neck Flap Surgery;* 12:15 pm—*Conservation Surgery Capsuled*

MILTON ORKIN, MD
Clinical Associate Professor, Department of Dermatology, University of Minnesota Medical School, Minneapolis, Minn.

TUESDAY, MAY 11: 3:30 pm—*The Resurgence of Scabies;* 12:15 pm—*What's New in Dermatology?*

HERBERT E. PEDERSEN, MD
Professor and Chairman, Department of Orthopedic Surgery, Wayne State University School of Medicine, Detroit, Mich.

WEDNESDAY, MAY 12: 2:00 pm—*Civilian Amputation Problem and Its Management;* 12:15 pm—*Mortality and Morbidity Associated with Treatment of Hip Fractures;* evening dinner speaker—*Management of Cervical Spine Injuries*

KENNETH T. RICHARDSON, MD
Professor and Chairman, Department of Ophthalmology, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

WEDNESDAY, MAY 12: 2:00 pm—*Chronic Open Angle Glaucoma: Diagnosis and Therapeutic Decision;* evening dinner speaker—*Medical Therapy of the Glaucomas*

RAYMOND G. SLAVIN, MD
Associate Professor of Internal Medicine, St. Louis University School of Medicine, St. Louis, Mo.

TUESDAY, MAY 11: 2:00 pm—*What's New In Pulmonary Hypersensitivity Diseases?* 12:15 pm—*Enzyme Detergents as a New Cause of Lung Disease*

ANNUAL MEETING PROGRAM
ARRANGEMENTS UNDER DIRECTION OF

Commission on Scientific Medicine

BEN R. LAWTON, MD _____ Marshfield
Chairman

ANTHONY V. PISCIOTTA, MD _____ Milwaukee
General Program Chairman

GERALD J. DERUS, MD _____ Madison
Scientific Exhibits

EINAR R. DANIELS, MD _____ Milwaukee
NORMAN O. BECKER, MD _____ Fond du Lac
SIGURD E. SIVERTSON, MD _____ Madison
EDWIN C. ALBRIGHT, MD _____ Madison
RICHARD H. WASSERBURGER, MD _____ Madison
JAMES W. MANIER, MD _____ Marshfield
ROBERT G. WOCHOS, MD _____ Green Bay

Ex officio:

GERALD A. KERRIGAN, MD _____ Milwaukee
Dean, Medical College of Wisconsin

PETER L. EICHMAN, MD _____ Madison
Dean, University of Wisconsin Medical School

VICTOR S. FALK, JR., MD _____ Edgerton
Medical Editor, *The Wisconsin Medical Journal*

NOON SCIENTIFIC LUNCHEONS

Make reservations early!

See reservation form on page 18

Special Annual Meeting Features!

MEDICAL ART SALON

Sculptures and Paintings
(watercolors—acrylics—oils)

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PHOTOGRAPHY CONTEST

Beautiful and exciting pictures taken by physicians. Featuring medicine, travel, people, animals, and general pictorial scenes.

ON DISPLAY IN THE EMPIRE ROOM,
HOTEL SHERATON–SCHROEDER

MONDAY, MAY 10

INTERNAL MEDICINE

9:30 am to 12:00 noon—Scientific Program

Plenary Session

PHYSIOLOGY OF THE SPLEEN, INDICATIONS FOR SPLENECTOMY
Anthony V. Pisciotta, MD, Milwaukee
Medical College of Wisconsin

THE CLINICAL ROLE OF SPLEEN SCANNING
Richard A. Holmes, MD, Milwaukee
Medical College of Wisconsin

SEQUESTRATION AND POOLING OF FORMED ELEMENTS BY THE SPLEEN
Richard H. Aster, MD, Milwaukee
Medical College of Wisconsin

HEREDITARY SPHEROCYTOSIS, MECHANISMS AND TREATMENT
Harry S. Jacob, MD, Minneapolis
University of Minnesota Medical School

THE CLINICAL SIGNIFICANCE OF SPLENOMEGALY
George L. River, MD, Marshfield
Marshfield Clinic

SURGERY OF THE SPLEEN
Fred A. Schaldach, MD, La Crosse
Gundersen Clinic

12:15 to 1:15 pm—Scientific Luncheons

THE DIAGNOSIS OF HEMOLYTIC ANEMIAS
Harry S. Jacob, MD, Minneapolis
University of Minnesota Medical School

REACTIONS TO DRUGS USED IN THE TREATMENT OF LEUKEMIA AND LYMPHOMA
George L. River, MD, Marshfield
Marshfield Clinic

2:00 to 4:30 pm—Scientific Program

LYMPHOMA & LEUKEMIA
Robert F. Schilling, MD, Madison
University of Wisconsin Medical School

HODGKIN'S DISEASE, RECENT ADVANCES
Richard A. Rudders, MD, Milwaukee
Medical College of Wisconsin

LONG-TERM SURVIVAL IN LYMPHOMAS
Donald R. Korst, MD, Madison
University of Wisconsin Medical School

ACUTE LEUKEMIA
Edward B. Crowell, Jr., MD, Madison
University of Wisconsin Medical School

WISCONSIN LYMPHOMA AND LEUKEMIA STUDY GROUP
Lee L. Schloesser, MD, Marshfield
Marshfield Clinic

RADIATION THERAPY OF LYMPHOMAS
Robert H. Greenlaw, MD, Marshfield
Marshfield Clinic

PATHOLOGY

12:15 to 1:15 pm—Scientific Luncheon

CHANGING PATTERNS IN LABORATORY MEDICINE
Jon V. Straumfjord, Jr., MD, PhD, Milwaukee
Medical College of Wisconsin

2:00 to 4:30 pm—Scientific Program

BLOOD COAGULATION AND THE SLIC SYSTEM
Anthony F. Cafaro, MD, Milwaukee
St. Joseph's Hospital

DIAGNOSTIC VIROLOGY IN THE HOSPITAL LABORATORY
Ronald R. Martins, MD, Milwaukee
St. Luke's Hospital

NEWER DIAGNOSTIC CONCEPTS IN HEPATITIS—THE AUSTRALIA ANTIGEN
Donald J. Kuban, MD, Milwaukee
St. Luke's Hospital

AN ACE IN THE HOLE (Anion-Cation Electroneutrality)
Harry F. Weisberg, MD, Milwaukee
Mt. Sinai Hospital

SEX AND THE SINGLE X
Lorraine F. Meisner, PhD, Madison
University of Wisconsin Medical School

RADIOLOGY

12:15 to 1:15 pm—Scientific Luncheon

CURRENT CONCEPTS IN THE TREATMENT OF BREAST CANCER
Simon Kramer, MD, Philadelphia
Thomas Jefferson University Hospital

2:00 to 4:30 pm—Scientific Program

RADIOTHERAPY OF BREAST CARCINOMA
Simon Kramer, MD, Philadelphia
Thomas Jefferson University Hospital

TREATMENT TECHNIQUES IN THE RADIOTHERAPY OF BREAST CARCINOMA
Ardow R. Ameduri, Jr., MD, Madison
University of Wisconsin Medical School

NEWER RADIATIONS—FAST NEUTRONS AND NEGATIVE PI MESONS
Albert L. Wiley, MD, Madison
University of Wisconsin Medical School

PREOPERATIVE IRRADIATION
Douglas King, MD, Milwaukee
Medical College of Wisconsin

4:30 to 5:30 pm—Business Meeting

WISCONSIN RADIOLOGICAL SOCIETY

6:00 pm—Dinner (members only)

WISCONSIN RADIOLOGICAL SOCIETY
Milwaukee Yacht Club
Speaker: *Mr. William Stronach,* American College of Radiology
Topic: THE LATEST FROM WASHINGTON

TUESDAY, MAY 11

GENERAL PRACTICE

9:30 am to 12:00 noon—Scientific Program

Plenary Session

PENICILLIN THERAPY, THE NEW, THE OLD DRUGS
Calvin M. Kunin, MD, Madison
University of Wisconsin Medical School

OSTEOPOROSIS, EVERYBODY'S PROBLEM
Frederic C. Bartter, MD, Bethesda, Md.
National Heart and Lung Institute

12:15 to 1:15 pm—Scientific Luncheons

CHRONOBIOLOGY IN HEALTH AND DISEASE
Frederic C. Bartter, MD, Bethesda, Md.
National Heart and Lung Institute

CURRENT PROBLEMS IN ANTIMICROBIAL THERAPY
Calvin M. Kunin, MD, Madison
University of Wisconsin Medical School

2:00 to 3:30 pm—Scientific Program

PROGRESS IN PEDIATRICS, 1971
Charles C. Lobeck, MD, Madison
University of Wisconsin Medical School

PROBLEM ORIENTED RECORDS
John H. Renner, MD, Madison
University of Wisconsin Medical School

NEUROLOGY

12:15 to 1:15 pm—Scientific Luncheon

THE EFFECT OF HEADACHE ON HISTORY
Arnold P. Friedman, MD, New York City
College of Physicians & Surgeons, Columbia University

2:00 to 4:25 pm—Scientific Program

FAMILIAL DISORDERS OF THE NERVOUS SYSTEM —MANAGEMENT OF THE PATIENTS AND THEIR FAMILIES
Richard F. Daly, MD, Madison
University of Wisconsin Medical School

NEW METHODS FOR EVALUATING NORMAL AND ABNORMAL CELLS IN THE CEREBROSPINAL FLUID
Paul R. Dyken, MD, Milwaukee
Medical College of Wisconsin

MANAGEMENT OF THE CHILD WITH ISOLATED OR FEBRILE CONVULSIONS
George J. Wolcott, MD, Madison
University of Wisconsin Medical School

AN OVERVIEW OF CHRONIC RECURRING HEADACHE
Arnold P. Friedman, MD, New York City
College of Physicians & Surgeons, Columbia University

EPILEPSY AND EATING
Francis M. Forster, MD, Madison
University of Wisconsin Medical School

THE ROLE OF BLOOD LEVEL EVALUATIONS OF ANTICONVULSANTS IN THE MANAGEMENT OF EPILEPTIC PATIENTS
Harold E. Booker, MD, Madison
University of Wisconsin Medical School

RECENT ADVANCES AND THE MANAGEMENT OF COMPLICATIONS IN THE L-DOPA TREATMENT OF PARKINSONISM
Gastone G. Celesia, MD, Madison
University of Wisconsin Medical School
Arlene N. Barr, MD, Madison
University of Wisconsin Medical School

2:00 to 5:00 pm—Special Scientific Program

RESIDENT-INTERN PAPERS
See box elsewhere on this page

ALLERGY

12:15 to 1:15 pm—Scientific Luncheon

ENZYME DETERGENTS AS A NEW CAUSE OF LUNG DISEASE
Raymond G. Slavin, MD, St. Louis
St. Louis University School of Medicine

2:00 to 4:00 pm—Scientific Program

WHAT'S NEW IN PULMONARY HYPERSENSITIVITY DISEASES?
Raymond G. Slavin, MD, St. Louis
St. Louis University School of Medicine

ADVANCES IN THERAPY OF ALLERGIC DISORDERS
S. Roger Hirsch, MD, Milwaukee
Medical College of Wisconsin

WHAT'S NEW IN INSECT HYPERSENSITIVITY?
Marshall H. Benner, MD, Milwaukee
Medical College of Wisconsin

WHAT'S NEW IN PENICILLIN SENSITIVITY?
Robert M. Heywood, MD, Marshfield
University of Wisconsin Medical School

continued on next page

SPECIAL PROGRAM

Presentation of

RESIDENT–INTERN PAPERS

TUESDAY, MAY 11 (2 TO 5 PM)

This is a competitive program with cash awards of $100 each for the two winning presentations. One award known as the W. S. MIDDLETON AWARD and the second as the HARRY BECKMAN AWARD

Chairman: *Ben R. Lawton, MD,* Marshfield
Chairman of the Commission on Scientific Medicine

Presentations will be limited to approximately ten minutes each.

JUDGES: Norman O. Becker, MD, Fond du Lac, Chairman; Walton D. Thomas, MD, Milwaukee; John F. Brown, MD, Rhinelander; and Howard Mauthe, MD, Fond du Lac

DERMATOLOGY

12:15 to 1:15 pm—Scientific Luncheon

WHAT'S NEW IN DERMATOLOGY?
Milton Orkin, MD, Minneapolis
University of Minnesota Medical School

2:00 to 3:30 pm—Scientific Program

ACNE WITH SPECIAL EMPHASIS ON THERAPY
Harry R. Foerster, Jr., MD, Milwaukee
Medical College of Wisconsin

PSORIASIS
Thomas W. Luther, MD, Appleton

DIAPER DERMATITIS
Frank H. Urban, MD, Wauwatosa

CONTACT DERMATITIS
Robert R. Baumann, MD, Monroe
The Monroe Clinic

DIAGNOSIS AND TREATMENT OF CUTANEOUS TUMORS
Daniel E. Hackbarth, MD, Milwaukee
Medical College of Wisconsin

DRUG ERUPTIONS
David J. Strang, MD, Eau Claire
Midelfort Clinic

ATOPIC DERMATITIS
Leonard S. Markson, MD, Milwaukee
Medical College of Wisconsin

DERMATOLOGIC SURGERY
Robert B. Pittelkow, MD, Milwaukee

THE RESURGENCE OF SCABIES
Milton Orkin, MD, Minneapolis
University of Minnesota Medical School

(NO Annual Dinner)

PRESIDENT'S RECEPTION

Tuesday, May 11
6 to 8 PM

Imperial Ballroom/Pfister Hotel and Tower

Everyone attending the Annual Meeting is invited to join President Jerry W. McRoberts in welcoming the new President, Dr. George A. Behnke, and his wife, at an informal reception.

FRUIT PUNCH **HORS D'OEUVRES**

Steve Swedish Music

WEDNESDAY, MAY 12

ANESTHESIOLOGY

12:15 to 1:15 pm—Scientific Luncheon

ANESTHESIA SPECIALTY BOARD REQUIREMENTS: QUESTIONS AND ANSWERS
James H. Matthews, MD, Minneapolis
University of Minnesota Medical School

2:00 to 5:00 pm—Scientific Program

MYTHS TO ABANDON
James H. Matthews, MD, Minneapolis
University of Minnesota Medical School

RESPIRATORY CARE OF ACUTE BOTULISM
Joan C. Paust, MD, Madison
University of Wisconsin Medical School

CLOSED CIRCLE HALOTHANE
Walter C. Bernards, MD, Milwaukee
Medical College of Wisconsin

A POSSIBLE CAUSE OF MALIGNANT HYPERPYREXIA DURING ANESTHESIA
Clinical Aspects:
Timoteo L. Galvez, MD, Madison
University of Wisconsin Medical School
Laboratory Aspects:
Robert F. Brucker, PhD, Madison
University of Wisconsin Institute for Enzyme Research

OTOLARYNGOLOGY

12:15 to 1:15 pm—Scientific Luncheon

CONSERVATION SURGERY CAPSULED
Joseph H. Ogura, MD, St. Louis
Washington University School of Medicine

2:00 to 4:15 pm—Scientific Program

RECONSTRUCTION HEAD AND NECK FLAP SURGERY
Joseph H. Ogura, MD, St. Louis
Washington University School of Medicine

SWELLINGS IN THE THROAT AND NECK
John M. Mills, MD, Green Bay
University of Wisconsin Medical School
David M. Wineinger, MD, Green Bay
University of Wisconsin Medical School

COMPUTER ANALYSIS OF LARYNGEAL CARCINOMA
James H. Brandenburg, MD, Madison
University of Wisconsin Medical School

4:15 pm—Business Meeting

WISCONSIN OTOLARYNGOLOGICAL SOCIETY

continued on next page

OPHTHALMOLOGY

12:15 to 1:15 pm—Luncheon

SECTION ON OPHTHALMOLOGY
No speaker; business meeting to follow

2:00 to 3:30 pm—Scientific Program

CHRONIC OPEN ANGLE GLAUCOMA: DIAGNOSIS AND THERAPEUTIC DECISION
Kenneth T. Richardson, Jr., MD, Pittsburgh
University of Pittsburgh

CLINICOPATHOLOGICAL CONFERENCE
Harry A. Easom, MD, Milwaukee
Medical College of Wisconsin
Guillermo B. de Venecia, MD, Madison
University of Wisconsin Medical School

6:00 pm—Dinner

MILWAUKEE OPHTHALMOLOGICAL SOCIETY
All ophthalmologists and interested physicians are welcome
University Club
Speaker: *Kenneth T. Richardson, Jr., MD,* Pittsburgh, University of Pittsburgh
Topic: MEDICAL THERAPY OF THE GLAUCOMAS

ORTHOPEDICS

12:15 to 1:15 pm—Scientific Luncheon

MORTALITY AND MORBIDITY ASSOCIATED WITH TREATMENT OF HIP FRACTURES
Herbert E. Pedersen, MD, Detroit
Wayne State University School of Medicine

2:00 to 4:30 pm—Scientific Program

CIVILIAN AMPUTATION PROBLEM AND ITS MANAGEMENT
Herbert E. Pedersen, MD, Detroit
Wayne State University School of Medicine

NON-OPERATIVE TREATMENT OF THE FRACTURED TIBIA
George L. Lucas, MD, Madison
University of Wisconsin Medical School

EFFECTS OF SODIUM FLUORIDE ON SKELETAL STATUS IN ELDERLY WOMEN
John M. Jurist, Jr., PhD, Madison
University of Wisconsin Medical School
C. Hugh Hickey, MD, Milwaukee
Medical College of Wisconsin

POSITIVE CONTRAST ARTHROGRAPHY OF THE KNEE
Andrew A. McBeath, MD, Madison
University of Wisconsin Medical School

6:30 pm—Dinner

WISCONSIN ORTHOPAEDIC SOCIETY
University Club
Speaker: *Herbert E. Pedersen, MD,* Detroit
Wayne State University School of Medicine
Topic: MANAGEMENT OF CERVICAL SPINE INJURIES

SURGERY

9:30 to 11:30 am—Scientific Program

Plenary Session

RESPIRATORY FAILURE
John Rankin, MD, Madison
University of Wisconsin Medical School

ARTIFICIAL VENTILATION—PRO AND CON
Claude A. Taylor, Jr., MD, Madison
University of Wisconsin Medical School

THE INHALATION THERAPY DEPARTMENT, THE INTERNIST AND THE SURGEON
Paul O. Simenstad, MD, Madison
University of Wisconsin Medical School

TITLE PENDING
John Wyatt, MD, Winnipeg, Manitoba, Canada
University of Manitoba

TITLE PENDING
Donald R. Kahn, MD
University of Wisconsin Medical School

12:15 to 1:15 pm—Scientific Luncheon

TITLE PENDING
John Wyatt, MD, Winnipeg, Manitoba, Canada

2:00 to 4:15 pm—Scientific Program

Section on Surgery
(Program details to be announced later)

4:30 pm—Presidential Address/6:30—Dinner

WISCONSIN SURGICAL SOCIETY

STATE MEDICAL SOCIETY OF WISCONSIN

Business Schedule

NOTE: *All business meetings* including House of Delegates, Reference Committees, Council, Council Committees will be held at the *Pfister Hotel and Tower* in Milwaukee

SATURDAY, MAY 8

Executive Committee of the Council
Council Meeting

SUNDAY, MAY 9

Section Delegates Caucus
First Session of the House of Delegates
Reports of officers, commissions, and committees, and new business
Reference Committees

MONDAY, MAY 10

Nominating Committee
Second Session of the House of Delegates
Reports of Reference Committees

TUESDAY, MAY 11

Third Session of the House of Delegates
Election of officers
Council Meeting
Presidential Reception

RESERVATION FORMS FOR

Noon Scientific Luncheons

NOTE: Attendance Limited! Please list 2 choices for each of the days you make reservations. List in order of preference. $4.00 per luncheon, including gratuities and taxes.

MONDAY, MAY 10

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. INTERNAL MEDICINE: The Diagnosis of Hemolytic Anemias—Harry S. Jacob, MD, Minneapolis
2. INTERNAL MEDICINE: Reactions to Drugs Used in the Treatment of Leukemia and Lymphoma—George L. River, MD, Marshfield
3. PATHOLOGY: Changing Patterns in Laboratory Medicine—Jon V. Straumfjord, Jr., MD, PhD, Milwaukee
4. RADIOLOGY: Current Concepts in the Treatment of Breast Cancer—Simon Kramer, MD, Philadelphia

Name of Leader *Name of Leader*

First Choice: _____ Second Choice: _____

TUESDAY, MAY 11

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. ALLERGY: Enzyme Detergents as a New Cause of Lung Disease—Raymond G. Slavin, MD, St. Louis
2. DERMATOLOGY: What's New in Dermatology?—Milton Orkin, MD, Minneapolis
3. INTERNAL MEDICINE: Bone Marrow Aspiration Biopsy—Anthony V. Pisciotta, MD, Milwaukee
4. GENERAL PRACTICE: Chronobiology in Health and Disease—Frederic C. Bartter, MD, Bethesda, Maryland
5. GENERAL PRACTICE: Current Problems in Antimicrobial Therapy—Calvin M. Kunin, MD, Madison
6. NEUROLOGY: The Effects of Headache on History—Arnold P. Friedman, MD, New York City
7. SURGERY: Wisconsin Committee on Trauma, American College of Surgeons

Name of Leader *Name of Leader*

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 12

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. ANESTHESIOLOGY: Anesthesia Specialty Board Requirements: Questions & Answers—James H. Matthews, MD, Minneapolis
2. OPHTHALMOLOGY: No speaker. Business meeting to follow luncheon
3. ORTHOPEDICS: Mortality and Morbidity Associated with Treatment of Hip Fractures—Herbert E. Pedersen, MD, Detroit
4. OTOLARYNGOLOGY: Conservation Surgery Capsuled—Joseph H. Ogura, MD, St. Louis
5. SURGERY: Title and Speaker to be announced
6. SURGERY: Title and Speaker to be announced

Name of Leader *Name of Leader*

First Choice: _____ Second Choice: _____

Number Luncheon Tickets ($4.00 each) . . . _____ for $ _____

Make Check Payable to: STATE MEDICAL SOCIETY OF WISCONSIN

NAME _____ **STREET** _____ **CITY** _____

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WISCONSIN MEDICAL JOURNAL
Vol. 70, No. 3 MARCH 1971

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Medical Society Issues Legislative Policy Statement

The State Medical Society of Wisconsin, through its Commission on Public Policy, has just released a policy statement expressing the Society's legislative views on major health and medical issues in 1971.

The statement outlines policy positions and established goals of the State Medical Society to help meet the needs of Wisconsin citizens in health care through legislative action.

Not all of these goals are expected to be met this year, but the start is being made now, the Society emphasized.

For the most part, these legislative positions on key issues have been established after long and due consideration over the course of many months and, in some instances, several years of study and deliberation.

It is expected that more than 2,000 bills will be introduced in the 1971 legislative session, of which at least 200 will have some bearing on health and medical care.

Be sure to contact your state assemblymen and state senators to express your opinion on major legislative health issues.

A complete listing of all constitutional officers and Wisconsin legislators, with addresses, appeared in the January BLUE BOOK issue of the *Wisconsin Medical Journal*. If this is not available, contact Society headquarters for a new listing.

In preparing this policy statement of legislative matters, it was possible only to highlight the Society's position on matters of public health and medical concern.

These positions have been established through action of the State Medical Society's House of Delegates, its Council, and its Commission on Medical Care Plans.

As legislative business proceeds, the Society's Commission on Public Policy will be analyzing each bill in detail and recommending the Society's stand based on what it believes is best for the health of the people of this state.

The following issues are reported in the policy statement:

HEALTH MANPOWER

Efforts to improve shortage and distribution take top priority

Efforts to improve the health manpower situation in Wisconsin is the cornerstone of the Society's 1971 legislative program. A position paper entitled "Health Manpower in Wisconsin in the 1970's" was communicated in November 1970 to the members of the Society, the state legislators, and the public. Additional copies are available upon request.

Earlier in 1970, the Society had requested the Wisconsin Legislative Council to establish a special committee dealing with health manpower. This was done. That committee is currently in the process of making recommendations to the legislature, and the State Medical Society has been well represented in its deliberations.

The Society's health manpower position calls for legislative action in these areas:

1. Rapidly expand the UW Medical School and the Medical College of Wisconsin to permit an admission level of at

continued on page 36

Society's Commission on Public Policy is Legislative Watchdog

The Commission on Public Policy, a standing committee of the State Medical Society's House of Delegates, reviews state legislative matters of concern to the medical profession. Commission chairman is W. T. Russell, MD of Sun Prairie. C. F. Broderick, MD of Wisconsin Dells is the vice-chairman. Twenty-one other physicians comprise the rest of the Commission, including one representative from the 16 scientific sections of the Society. Society president, J. W. McRoberts, MD of Sheboygan; vice-president, G. A. Behnke, MD of Kaukauna; and secretary, E. R. Thayer of Madison are ex officio members of the Commission. A complete listing of Commission members appeared in the January BLUE BOOK issue of WMJ at page 62.

Dr. Russell

Medical Society Issues Legislative Policy Statement

continued from page 35

least 160 students almost immediately.

2. Provide the additional funds necessary to increase the output of physicians.
3. Equalize the tuition at the state's two medical schools and expand the enrollment of Wisconsin residents in both schools.
4. Expand the opportunity for quality residency training programs in Wisconsin.
5. Expand the preceptorship approach and increase the recruitment of graduating students for residency in Wisconsin.
6. Expand efforts to attract physicians to practice in Wisconsin.
7. Provide additional long-term, low interest or no interest loans to assure that finances do not bar an otherwise qualified student from attending medical school in Wisconsin. Experimentation should be undertaken with loan forgiveness programs related to practice in "shortage" areas of the state.
8. Develop an acceptable initial approach to the recognition and utilization of physician assistants.
9. Expand the production of allied and ancillary health personnel.

MENTAL HEALTH

Mental health code revision supported but with amendment on commitment procedure

The Society has supported the revision of Chapter 51, the state's mental health code, but in supporting this legislation, the Society emphasizes that it should be amended to provide that no commitment procedure should be completed without the need for such a commitment being certified by a physician.

BLOOD TRANSFUSION

Liability exemption supported for those supplying blood as service

The Society is supporting legislation which would exempt from liability any firm or corporation involved in the rendition of procuring, processing, distributing or using whole blood, plasma, blood products, blood derivatives, and other human tissues. It is felt that this legislation is necessary to alleviate the possibility of blood banks and others providing these extremely valuable medical services from being held liable for acts which are at present beyond their control.

SAFETY EYE GLASSES

Safety glasses urged for students in injury-prone school courses

Support is being given to legislation which would require that safety glasses be used by students in academic classes such as chemistry and industrial arts. The injury rate occurring in such classes could be cut dramatically, and it is felt that if industry has adopted safety glasses as a standard, the Society can do no less than encourage the use of safety glasses by students who by virtue of their academic endeavors are also placed in positions which could endanger their eye sight.

MOTOR VEHICLES DIVISION MEDICAL ADVISORY BOARD

Would alleviate physician's work in determining driver ability

Creation of medical advisory boards to the Division of Motor Vehicles is recommended on a regional area and statewide basis. At present, the physician is asked to complete many forms concerning his patient's medical limitations which might affect his ability to operate a motor vehicle. While this is within the purview of the physician, he should not be asked to determine whether a person in the last analysis should be permitted to drive. This decision must be made by the Motor Vehicle Division, and it is the Society's position that the Division should have the benefit of consultation with medical advisory boards.

SENATE–ASSEMBLY COMMITTEES HANDLING HEALTH LEGISLATION

Most legislation dealing with health and medical care is handled by one of the following committees:

Senate Committee on Health and Social Services

James C. Devitt (R–Greenfield), Chrm.
Raymond F. Heinzen (R–Marshfield), V. Chrm.
Everett Bidwell (R–Portage)
Carl W. Thompson (D–Stoughton)
Wayne F. Whittow (D–Milwaukee)

Assembly Committee on Health and Social Services

Joseph C. Czerwinski (D–Milwaukee), Chrm.
William Rogers (D–Kaukauna), V. Chrm.
Harvey L. Dueholm (D–Luck)
Harout O. Sanasarian (D–Milwaukee)
Michael P. Early (D–River Falls)
Marjorie M. Miller (D–Madison)
Marlin D. Schneider (D–Wisconsin Rapids)
Joanne M. Duren (D–Cazenovia)
Kenneth J. Merkel (R–Brookfield)
William G. LaFave (R–Peshtigo)
Kenneth M. Schricker (R–Spooner)

Chiropractic bill 171,A. re Workmen's Compensation has been referred to the *Assembly Committee on Labor.* Its members are:

William A. Johnson (D–Milwaukee), Chrm.
Joseph L. Looby (D–Eau Claire), V. Chrm.
Robert L. Jackson, Jr. (D–Milwaukee)
Sam L. Orlich (D–Milwaukee)
Eugene Dorff (D–Kenosha)
Glenn E. Bultman (D–Milwaukee)
Virgil D. Roberts (D–Holman)
Leo O. Mohn (D–Woodville)
James N. Azim (R–Muscoda)
William S. Schwefel (R–Oakfield)
Jon R. Guiles (R–Oshkosh)

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MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

CHIROPRACTIC

Further extension of privilege or practice in chiropractic must halt

There is serious doubt as to the wisdom of having granted to chiropractic any type of licensing for the diagnosis or treatment of the sick. At the very least, the protection of the public health demands an immediate halt to any further extension of privilege or practice to this group. Chiropractic in Wisconsin continues its perennial efforts to expand its legislative authority by seeking passage of bills to provide chiropractic services under Workmen's Compensation, in private health insurance policies, and under Medicaid (Title 19).

The legislature is being importuned by this group to achieve by law what they cannot accomplish through education and public acceptance of demonstrable training and skill.

The most telling evidence against the efforts of chiropractic is contained in a report of the Department of Health, Education, and Welfare to the United States Congress, December 28, 1968, when it recommended that chiropractic services not be covered by Medicare:

> "Chiropractic theory and practice are not based upon the body of basic knowledge related to health, disease, and health care that has been widely accepted by the scientific community. Moreover, irrespective of its theory, the scope and quality of chiropractic education do not prepare the practitioner to make an adequate diagnosis and provide appropriate treatment."

OTHER LEGISLATION

Consent by Minors for VD Treatment—The Society favors legislation which would permit minors to give consent with or without the approval of parents or guardians for treatment of venereal disease. It is felt that the current epidemic of VD requires such legislation for the protection of the public.

Generic Prescribing and Dispensing—The Society is opposed to legislation which would mandate generic name prescribing and dispensing in every instance. This position is based on the Society's belief that there is substantial doubt about the equivalency of drugs, there are problems of terminology, and no evidence that such legislation would, in fact, provide the patient with better drugs at lower cost.

Family Planning—For more than four years, the Society has supported the modernization of Wisconsin's family planning laws. The House of Delegates, in May 1970, adopted a resolution calling upon the Society to actively support legislation which would allow physicians to provide contraceptive measures and family planning information to all patients consistent with good medical practice.

Sterilization—The House of Delegates, in May 1970, adopted a position of support for a law to clearly establish that sterilization can be performed at the voluntary request of the patient.

Abortion—The Society, by action of the House of Delegates in May 1970, is authorized to support legislation which would clarify current court rulings on abortion and clearly establish the right of the physician to abort an unquickened product of a conception. The Society's Commission on Medical Care Plans is reviewing several bills on this subject and has determined that once court rulings have been developed further, it will be in a position to establish which legislative proposals will best implement the Society's position.

* * *

Bills dealing with many other subjects have already been introduced or will be in the coming months. Legislation of major import to the profession will be summarized by bill number, author, and brief explanation of intent. This information will be communicated to physicians by direct bulletin, through the Regional Services representatives of the Society, and the GREEN SHEET section of the *Wisconsin Medical Journal.*

Physicians are encouraged to contact their legislators to provide them with adequate information on which to base sound legislative action. Questions may be answered and further information obtained at any time by contacting State Society officers or the Society headquarters in Madison.

* * *

NOTE: The following is a listing of some of the key bills and their status as of March 17, 1971. Further information on other bills and an updating of status will appear in future issues of the GREEN SHEET, in legislative bulletins, and in special communication to officers of county societies.

Bill	*Subject*	*Current Status*
206, A.	Generic Prescribing—Introduced by over 40 representatives and would require physicians to prescribe by generic name and also require labeling by generic name. SMS OPPOSES	Hearings held by Assembly Committee on Health and Social Services
171, A.	Chiropractic Treatment Under Workmen's Compensation—Introduced by Representatives Atkinson (D–Milwaukee) and Looby (D–Eau Claire). SMS OPPOSES	Hearings held by Assembly Committee on Labor
295, A.	Chiropractic Treatment Under Workmen's Compensation—Introduced by Representatives Swoboda (D–Door–Kewaunee), Stack (D–Superior) and Hephner (D–Chilton). SMS OPPOSES	Referred to the Assembly Committee on Health and Social Services
2, S.	Family Planning—Introduced by Senator Soik (R–Whitefish Bay), would remove contraceptives from the list of indecent articles and enable sale by physician or pharmacist. Sale would be restricted to those over age 18 except under certain circumstances. SMS SUPPORTS with amendment to remove age limitation.	Referred to the Senate Committee on Health and Social Services
130, S.	Family Planning—Introduced by Senator Risser (D–Madison), would also remove contraceptives from the list of indecent articles and allow physician to provide family planning information as does Senate Bill 2. There is no 18-year age limit set forth in this legislation. SMS SUPPORTS	Public hearing held by the Senate Judiciary Committee

continued on page 38

SMS Hot Line

MUSEUM OF MEDICAL PROGRESS in Prairie du Chien will be opening April 15 with the nation's first educational ecology exposition. Exposition includes 25 specially prepared exhibits demonstrating the causes, effects, and probable solutions to many of our environmental problems. Now in its eleventh season, the Museum is operated and owned by the State Medical Society of Wisconsin. Hours are from 8 a.m. to 5 p.m. but will be open evenings during the summer months. As was done last year, the Museum has set up a flood information service. Anyone wishing up to date status of the Mississippi River's flood level may phone (608) 326-8715.

SOCIETY'S ANNUAL MEETING plans are just about complete with a condensed version of the program appearing in this issue at pp 11-18. The House of Delegates sessions are being held May 9–11 at the Pfister Hotel and Tower. All scientific programs and exhibits are scheduled at the Sheraton-Schroeder Hotel on May 10-12.

CHIROPRACTORS UNITED! The "mixers" and the "straights" among chiropractors have now united into a single organization known as the Wisconsin Chiropractic Association. Together they have lodged an energetic "public service" program which involves statewide posture queen pageants, a vigorous campaign to convince insurance companies to include chiropractic in their health and accident policies, an advertising campaign in newspapers, high school and college annuals, free chiropractic books to all school libraries, a broadened scholarship tuition program, expanded contacts with the Wisconsin Guidance and Personnel Directors Association, and energetic participation in the State Governor's Conference on Aging.

KEY BILLS AND THEIR STATUS *continued from page 37*

160, S.	Consent for Medical Treatment by Minors—Introduced by Senators Keppler (R–Sheboygan) and Risser (D–Madison), would permit minors to be treated with or without parent's consent for health care which, if denied, would be a significant hazard to the health of the patient and to the public. SMS supports such legislation ONLY to the extent that it permit treatment of VD without parental consent.	Public hearing held by the Senate Judiciary Committee and passage recommended
144, S.	Safety Eye Glasses—Introduced by Senators Soik (R–Whitefish Bay), Devitt (R–Milwaukee), Steinhilber (R–Oshkosh) and Murphy (R–Waukesha), would require that students in certain academic classes such as chemistry and industrial arts, etc. wear safety glasses. SMS SUPPORTS	Public hearing held by Senate Committee on Education and passage recommended
51, S.	Recodification of the Mental Health Statutes—Introduced by the Wisconsin Legislative Council. SMS SUPPORTS with amendment to provide that no commitment procedure should be completed without the need for such commitment to be certified by a physician.	Public hearing held by the Senate Health and Social Services Committee
202, S.	Chiropractic and Private Health Insurers—*Introduced by the Senate Committee on Health and Social Services, would make it mandatory for private health insurance plans to provide coverage for chiropractic services. SMS OPPOSES	Public hearing held by the Senate Health and Social Services Committee
203, S.	Chiropractic Services Under Medicaid (Title 19)—*Introduced by the Senate Committee on Health and Social Services, would require payment for chiropractic under Medicaid. SMS OPPOSES	Public hearing held by the Senate Health and Social Services Committee
204, S.	Chiropractic Treatment Under Workmen's Compensation—*Introduced by the Senate Committee on Health and Social Services, would require payment for chiropractic treatment under Workmen's Compensation. SMS OPPOSES	Public hearing held by the Senate Health and Social Services Committee

* Members of the Senate Health and Social Services Committee which introduced chiropractic bills 202, 203, and 204 are Senators Devitt (R–Milwaukee), Heinzen (R–Marshfield), Bidwell (R–Portage), Thompson (D–Stoughton) and Whittow (D–Milwaukee).

PRESIDENT'S PAGE

State of Ferment

It is obvious that Congress, during the coming months, will devote a good deal of time and effort to the study of national health insurance plans. Hardly anyone would be surprised if Congress enacted a national health plan of some type during this or the next session.

In a sense, this country is in a state of ferment as health care proposals are springing up like "topsy" on Capitol Hill. No less than seven major proposals have emerged at this point.

Surprising as it may seem to some, the AMA's Medicredit plan is getting top billing as one of those proposals meriting serious consideration. It would utilize the private insurance industry to provide certain basic coverage with complete subsidy for purchase of the protection for the poor, and tax relief for the remainder of the population who would be brought under the plan. The proposal includes protection against catastrophic expense as well as basic outpatient services to encourage preventive health care. It has nearly 125 House and Senate co-sponsors. It appears to be favored by a majority of the physicians with whom I talk, but it has lots of competition.

The most prominent of these plans is that offered by President Nixon a few weeks ago. Like the AMA Medicredit proposal, it would not overthrow what is good in the present system but would try to improve that which is poor or not working properly.

Mr. Nixon's approach would provide a basic standard hospital plan plus broad outpatient physicians services topped by a catastrophic benefit allowing coverage for up to $50,000 of such expense per person. Government would share premiums with employers, with the latter eventually paying 75%. For persons not covered by employer plans, their portion of premiums would be scaled from nothing to about 75%.

Furthermore, the President's plan calls for a health maintenance organization as well as a professional standards review agency, both of which deserve serious study.

The third major proposal is that affiliated with the name of Senator Edward Kennedy. It has attracted the endorsement of labor on a national basis. Essentially, his proposal is a sweeping national health insurance system with emphasis on prepaid group practice. Even the backers of this bill estimate the starting cost at a whopping $57 billion. It would seem to force the private insurance industry out of business and it would appear difficult for the solo or small group practicing physician to survive because of the substantial bonuses to those physicians in capitation plans.

Which plan should we favor? Senator Kennedy's proposal would seem to be one superbureaucracy added on to another. Both the AMA Medicredit proposal and the President's plan seek to preserve and extend the voluntary system of health care in our country. Furthermore, the Nixon plan recognizes that poverty itself is not the real cause of the country's health problems. No matter how much money is poured into any health insurance plan, it would prove to be inadequate if there is little motivation for the physician to deliver and insufficient manpower to make the system function. Nor would health insurance alone relieve those aspects of our health care problems which are so closely related to malnutrition, pollution, poor housing, and educational deficiencies.

J. W. McRoberts, MD

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

The Great Tolbutamide Controversy

SELDOM HAS THE PUBLICATION of a scientific study evoked such vigorous controversy as that of the organization known as the University Group Diabetes Program (UGDP). Consisting of an affiliation of 12 university centers involved in the study and treatment of diabetes, the Group produced a report that seems to indicate that diet plus tolbutamide (or any other sulfonylurea) is not more effective in prolonging life among mild, adult-onset diabetic patients than diet alone; and the use of the classic therapy may be less effective than diet alone or diet plus insulin in the prevention of cardiovascular deaths.

At the present time it is reported that there are over a million and a half patients taking oral hypoglycemic drugs, which represent a $100 million industry. But more important, at stake are the scientific reputations of a large number of clinicians and investigators, not to mention the legal liability of every doctor administering an oral hypoglycemic to a diabetic patient who might develop a cardiovascular ailment.

The Group's report by itself—a monumental work running to more than 100 pages of text, tables, and graphs—might have been accepted quietly as a valuable addition to the corpus of scientific medical knowledge except for some unusual events prior to its publication. At a meeting of the American Diabetes Association, in St. Louis, in June 1970, presentation was made of the results of the study. The rather sensational findings received widespread news coverage, and the ADA soon afterward sent a letter to its membership endorsing the validity of the findings. The Council on Drugs of the American Medical Association did likewise, and the Food and Drug Administration, with the study still not published, sent an official "Current Drug Information" bulletin to all physicians in the United States reporting the conclusions of the study, with endorsement of the FDA implied.

The FDA bulletin went on to warn that "the use of Orinase (tolbutamide), Diabinese (chlorpropamide), and Tolinase (tolazamide) should be limited to those patients with symptomatic adult onset nonketotic diabetes mellitus which cannot be adequately controlled by diet or weight loss alone and in whom the addition of insulin is impractical or unacceptable."

The UGDP study was finally published in December 1970 and was immediately attacked by medical scientists who have advocated the theory that careful control of blood sugar levels through the use of hypoglycemic drugs and diet can retard development of the vascular complication of diabetes. Needless to say, the debate is being followed with intense interest by thousands of physicians who foresee malpractice suits instituted by patients who suffer bad results following therapy involving the use of tolbutamide or similar drugs.

A group of distinguished scientists studying problems of diabetes and other impairments of metabolism scored the study publicly, taking the unusual step of denouncing it in a letter to the editors of the *New York Times*. A manifesto was also circulated criticizing the study on a number of points, hoping to offset the influence of the study. They claimed that the findings of the UGDP is contrary to the experience with large numbers of diabetic patients, both in this country and abroad, over a longer period than that involved in the UGDP study; that there was really no significant difference in the mortality among the four treatment groups used in the study; and that the starting risk factors among the four studied groups precluded any valid projection or, indeed, even a valid statistical evaluation. They insist further that the UGDP statisticians manipulated the data to produce the findings they reported and that the same data, under the application of different statistical methods would have yielded contradictory results.

The Committee has also criticized the use of a constant dosage of tolbutamide in the study, since the usual clinical practice is to vary the dosage according to the requirements of the patient.

Without getting into the argument regarding the validity of the UGDP study, it seems obvious that the Food and Drug Administration did indeed go off halfcocked in this instance. The recommendations may eventually prove to be correct, but at the present time there is not sufficient evidence available to validate them. And since there is not general consensus in the scientific community to support the recommendations of the FDA, they should not have been made now. Moreover, no recommendation from the FDA or the AMA or the ADA should have been made before the UGDP study had been published and evaluated by diabetologists everywhere.

On the other hand, the findings of the UGDP study should not be rejected out of hand, as some of its opponents seem to be doing. Assuming that the study was not large enough to be statistically conclusive, assuming that the variations of results from one location to the next made the conclusions suspect, and assuming that the selection of patients at the beginning of the project may have loaded the probability for the conclusion reached, there is still no reason to conclude that the UGDP is not on the track of important findings.

It is still conceivable that control of the blood glucose level may have no effect on the vascular lesions characteristic of diabetes. It may indeed be that hyperglycemia is merely a concomitant of diabetes and that both, as well as the changes in blood vessels, are symptomatic of over-rapid aging. And it may well be that diet alone, without sulfonylureas, will suffice in the control of stable, adult-onset diabetes.

If the UGDP project didn't produce the conclusive proof we are seeking, it doesn't follow that the proof doesn't exist.

What is clearly needed is a long-term, statistically valid, thoughtfully planned study that will produce the evidence to substantiate or negate the use of oral hypoglycemics for diabetes. If a refined study of such a nature proceeds from the great tolbutamide controversy, all the heat and invective it generated will not have been in vain.

The article on "The Oral Hypoglycemic Agents" in this issue of the *Wisconsin Medical Journal* is one of the most thoughtful and incisive commentaries on the subject that has ever appeared. Written by Edgar S. Gordon, MD, Professor of Medicine at the University of Wisconsin Medical Center, it delineates important characteristics of the disease, sweeps away obfuscation surrounding its relationship with the oral drugs and provides great heuristic stimulus. Doctor Gordon's paper must surely become a permanent addition to every physician's library.

—DNG □

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

ERROR NOTED IN ARTICLE ON LACTIC ACIDOSIS IN OCTOBER 1970 ISSUE

To the EDITOR:

Our attention has been directed to a recent article by Claude A Taylor, M.D., which appeared in your publication under the section COMMENTS ON TREATMENT: Lactic Acidosis in Hypoxia and Its Treatment (*Wis. Med. J.*, 69:237–238, October 1970). We feel this article is unjustly critical of the use of 5% sodium bicarbonate solution in 500 ml bottles. Although Abbott Laboratories is not mentioned, we do offer this concentration and size of sodium bicarbonate solution for intravenous infusion. Accordingly, we have a responsibility to clarify any misunderstanding which we feel may arise as a result of the following statements which are made in the article and which we quote as follows:

> "One must guard, therefore, against the overenthusiastic use of sodium bicarbonate in reversing the acute lactacidosis of hypoxia. This is especially true in those hospitals where 5% sodium bicarbonate solutions are stored in 500 cc bottles—one bottle contains 595 milliequivalents! Inadvertent infusion of an entire bottle of this solution has been observed. Thereby, gross overdosage with buffer can occur, leading to metabolic alkalosis, respiratory depression, and shift of the oxyhemoglobin dissociation curve to the left."

A 500 ml. bottle of 5% sodium bicarbonate solution contains 297.5 (not 595) milliequivalents of bicarbonate (HCO_3^-). Evidently the 595 value was derived from the total milliequivalent (mEq.) value of the solute — sodium (Na^+) 297.5 and bicarbonate (HCO_3^-) 297.5. It is incorrect to sum these two ions in stating the buffering capacity of the solution. Furthermore, we take issue with the author's implied criticism that inadvertent infusion of an entire bottle (500 ml.) of 5% sodium bicarbonate is necessarily dangerous. For example, in a patient weighing 90 kg., with a severe base deficit of 20 mEq./kg. (the author states that base deficits of 5 mEq./kg. or less are usually not treated), the dose of bicarbonate needed would be (0.3)(90)(20) = 590 mEq. The author also states: "In practice, however, most people do not completely reverse base deficit, but divide the dosage of sodium bicarbonate by two, thereby correcting the base deficit about half-way on the first attempt." This would mean that on the first attempt to correct the acidosis in this hypothetical case 270 mEq. of bicarbonate should be given. Since one 500 ml. bottle of 5% sodium bicarbonate contains 297.5 mEq. of bicarbonate ion, it is not inappropriate to consider that, given a sufficiently heavy patient, or one with a sufficiently low base deficit, the entire 500 ml. bottle of 5% sodium bicarbonate could be suitably administered without gross overdosage.

We certainly agree that care is essential in avoiding overdosage with bicarbonate therapy, but it does not seem inconceivable that all or most of the contents of a 500 ml. bottle of 5% sodium bicarbonate may indeed be necessary under certain circumstances to correct an acidotic state. Also, we would agree that large volume containers can sometimes lead to the careless assumption that the entire contents constitutes a proper single dose.

We have no evidence in our Drug Reaction Reporting System that the 500 ml. sodium bicarbonate solution 5% (297.5 mEq.) has led to any abuse from the standpoint of overdosage. To the contrary, this dosage size is convenient for intermittent infusion in the management of severely acidotic patients, provided of course that blood pH, P_{CO_2} and base deficit are closely followed.

HAROLD D. KAUTZ, MD
Manager Medical Information
Hospital Products Division
Abbott Laboratories

To the EDITOR:

Dr. Harold D. Kautz of Abbott Laboratories has pointed out an error in my recent article in the *Wisconsin Medical Journal:* Taylor, C. A., Lactic Acidosis in Hypoxia and Its Treatment, *Wis. Med. J.*, 69:237–238, October 1970.

Dr. Kautz is quite right. The statement should have read that one *liter* contains 595 milliequivalents, and that inadvertent infusion of an entire *liter* of this solution has been observed, etc.

The intent of the paragraph still stands, however—that care must be exercised during the rapid infusion of large doses of sodium bicarbonate. Dr. Kautz would agree "that large volume containers can sometimes lead to the careless assumption that the entire contents constitutes a proper single dose."

My intent here is hardly to impugn the integrity of manufacturers who prepare and market large volume containers of sodium bicarbonate, but rather to warn against that therapeutic school of thought which holds that if one bottle of a substance is good, then two bottles are automatically better. I am not aware that blood–gas analysis was adequately monitored in the instance to which I refer.

I hope that this further explanation and correction is useful.

CLAUDE A. TAYLOR, JR, MD
Associate Professor of Anesthesiology
University of Wisconsin Medical Center □

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

SECTION OPHTHALMOLOGY

MARCH 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN SOCIETY FOR THE PREVENTION OF BLINDNESS SPONSORS EDUCATIONAL PROGRAM FOR WISCONSIN NURSES

Last fall the Wisconsin Society for the Prevention of Blindness (WSPB), the State Department of Health and Social Services—Bureau of Community Health Services, and the State Department of Public Instruction cosponsored 5 one-day workshops for all Wisconsin public health and school nurses.

Purpose of the workshops was to assist nurses in providing better eye health and safety for children from preschool age to adolescence and to facilitate the nurses to problem-solve their own particular problems in the area of school eye health and safety programs.

Workshops were held in 1970 at Whitewater University, August 25; Three Lakes, September 16; Appleton, September 17; Eau Claire, September 23; and Tomah, September 24. It was hoped that the diversity of conference locations would enable nurses from all parts of the state to attend.

The day-long program was divided into two sessions. The morning session began with the viewing of "Before We Are Six," the WSPB's new training film for volunteer vision screeners, and was followed by five formal presentations. Participants giving these presentations varied depending upon the location of the program. The following material was covered:

Growth and development of the child, given by Horace K. Tenney, III, MD and Gertrude E. Howe, MD, Madison pediatricians.

Medical direction and interpretation relative to visual development and organic functional deviations in vision of children, by ophthalmologists Walter E. Gager, MD of Waukesha and Milwaukee, Gordon L. Backer, MD of Wausau, Herbert Giller, MD of Milwaukee, Frank J. Brown, MD of Eau Claire, and Rodney J. Sturm, MD of Madison.

The educator's interpretation and management of learning and reading problems, to include dyslexia, by Burton F. Rodee, PhD, associate professor of Special Education, Wisconsin State University–Whitewater; and Thomas J. Scharf, supervisor of Special Education, Orthopedic and Special Learning Disabilities Program, Wisconsin Department of Public Instruction.

Program planning, implementation, techniques, follow-up, and evaluation of vision screening programs, by Mrs. Charles B. Lansing, executive director of the WSPB.

The nurse's role in the total vision program, by Miss Helen Woods, RN, nurse consultant at the National Society for the Prevention of Blindness.

The afternoon session consisted of two informal question and answer periods affording each nurse the opportunity to question ophthalmology about eye problems in children; education and ophthalmology about learning disabilities and reading problems as they may or may not relate to the eye; the WSPB concerning screening techniques, criteria, follow-up, and the like, and the nurse's role in the school and community.

Additionally, the WSPB prepared a kit of resource publications, a bibliography of additional reading materials, and a list of available sources from which suggested materials might be obtained. This kit was given to every nurse in attendance. No fee was charged for the workshops.

This combined effort on the part of the Wisconsin Society for the Prevention of Blindness, a voluntary health agency, and the state health and educational agencies resulted in a highly successful professional education program. A total of 269 nurses attended; 93 county nurses; 73 city nurses, and 103 school nurses. Each nursing agency in the state had representation at one of the five sessions.

Comments on the workshop evaluation sheets submitted by the nurses proved the value of the program as did the following avalanche of requests for publications, materials, and assistance in both preschool and school vision screening programs received by the WSPB. Secondly, the workshops were tangible evidence of close cooperation between state agencies, a voluntary health agency, and professional volunteers to produce a better and more well rounded program than one group could provide by itself.

DATE TO REMEMBER

April 27: Milwaukee Ophthalmological Society meeting. Charles Jaeckle, MD, speaker.

SECTION'S ANNUAL MEETING PROGRAM

The Section on Ophthalmology will meet for a business session at a noon luncheon Wednesday, May 12, at the Sheraton–Schroeder Hotel in Milwaukee during the Annual Meeting of the State Medical Society of Wisconsin. Details of the Ophthalmology scientific program, also to be held May 12, appear in this issue at page 17. □

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NEWS HIGHLIGHTS

Madison Hosp. Opens Hemodialysis Unit

Methodist Hospital of Madison in January opened a "new" area of its hospital—the Hemodialysis Center—which will serve people in all of Wisconsin and nearby surrounding states.

The entire third floor of the "old" Methodist Hospital building was completely remodeled to provide facilities for patients with kidney disease.

This new regional Hemodialysis Center has been established with the support of a grant from the Wisconsin Regional Medical Program. The grant is being administered by the Kidney Foundation of Wisconsin which has plans for developing a statewide hemodialysis program through community hospitals and home care training.

The Hemodialysis Center based at Methodist Hospital is under the direction of W. D. Shelp, MD. The Center will perform two distinct functions for patients with kidney disease.

First, it will provide an in-center treatment area, equipped with five beds, which will be used for the care of both acute and chronic patients. In-center treatment may be used for patients who require dialysis on a temporary or permanent basis and also for selected patients who are awaiting a kidney transplant.

Secondly, a home dialysis training unit will provide instruction for patients and members of their families in the principles and techniques of home dialysis.

It is estimated that it will be possible to train about 40 new patients per year for home dialysis with these facilities at Methodist Hospital. Physicians and nurses from various parts of the state also will receive training at this Center.

Emergency Physician Program Started at Eau Claire Hospital

Sacred Heart Hospital in Eau Claire on February 1 began an emergency physician program providing full-time physician coverage in the emergency department on a 24-hour daily basis.

Three Eau Claire physicians have given up their private practice to provide the medical service—MDs Roland A. Buckley,* William G. Cameron,* and James K. Martins.* The hospital hopes to obtain one more physician to complete the program.

Dr. Martins has been appointed emergency program coordinator with the medical staff and the hospital administration.

MCW Awarded Liver Research Grant

A $163,610 grant to continue the search for successful treatment of liver failure has been awarded to the Medical College of Wisconsin by the John A. Hartford Foundation, New York City.

The grant supports research efforts on liver transplantation and on techniques designed to support the liver while it repairs itself.

Joseph C. Darin, MD,* heads the MCW liver research program. He is professor and acting chairman of the Medical College surgery department and acting director of surgery at Milwaukee County General Hospital.

Wisconsin Doctors Prepare for Family Practice Exam

Paul S. Haskins, MD,* River Falls, and Joseph J. Young, MD,* Appleton, recently attended a two-week course designed to prepare physicians for the examination for board certification in family practice sponsored by the University of Nebraska Medical Center in Omaha.

Fifty-six physicians from 16 states participated in the course. The physicians received almost 15 hours of instruction and concentrated experience in test taking, which has undergone radical changes in recent years.

PHYSICIAN BRIEFS

James F. McIntosh, MD*

. . . Madison, recently was elected chief of the medical staff at Madison General Hospital. Also elected were MDs C. Robert Jackson,* vice-chief of staff; Edward H. Kolner,* secretary-treasurer; and Glen J. Stuesser,* trustee to the Dane County Medical Society, all from Madison.

Merlin J. Olson, MD*

. . . Monroe, recently was elected chief of staff at St. Clare Hospital, Monroe. Others elected were MDs Philipp H. Marty,* New Glarus, vice-chairman; Hans Kneubuhler,* Monroe, secretary; and Robert R. Baumann,* Monroe member of the executive committee.

Blair T. Bonell, MD*

. . . Kenosha, recently was elected president of the medical staff at Memorial Hospital, Kenosha. Also elected were Kenosha MDs James T. Duncan,* vice-president, and Reinaldo Barreto,* secretary.

Clarence A. Klasinski, MD*

. . . Stevens Point, an orthopedic surgeon, who has been studying hip joint replacement surgery with Dr. J. Charnley, Wrightington, England, recently returned to his office. Drs. J. Charnley and B. Weber, St. Gall, Switzerland, devised the technique which is now allowed in this country as an experimental process, under the supervision of the Food and Drug Administration.

Patricia J. Stuff, MD*

. . . Bonduel, recently was awarded a plaque and a traveling trophy for the "Outstanding Woman of the Year" by the Shawano chapter of the Business and Professional Woman's Club. Doctor Stuff was honored for her work in the field of medicine and community interests.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Anne E. Roethke, MD*

. . . Milwaukee, an anesthesiologist at Trinity Memorial Hospital, Cudahy, recently returned from a 22-day flight over the southernmost part of Africa. Doctor Roethke, who has had a pilot's license since 1945, is a member of the Ninety-Nines, an international organization of women pilots founded by Amelia Earhart.

Douglas O. Clark, MD*

. . . Brookfield, recently became associated with Medical Associates of Menomonee Falls. Doctor Clark is an assistant professor of Gynecology and Obstetrics at the Medical College of Wisconsin. He is a graduate of Ohio State University School of Medicine, served his internship at Milwaukee County General Hospital, and completed his residency in Obstetrics–Gynecology at Ohio State University Hospital, Columbus, Ohio.

H. Thomas Treiber, MD

. . . Omaha, Nebr., recently joined the medical staff of the Tomah Veterans Hospital. Doctor Treiber graduated from Georgetown University School of Medicine and completed his internship and residency in surgery at St. Mary's Hospital, Rochester, N. Y. He was engaged in private practice in Rochester, New York and Omaha, Nebr., and served in the medical corps of the United States Army from 1946–1948.

Kenneth A. Morrow, MD*

. . . Ashland, recently was presented a plaque in appreciation for his services as treasurer and director of the Ashland Area Chamber of Commerce. He had held the position from 1968–1970.

Max O. Bachhuber, MD*

. . . Alma, recently was appointed coroner in Buffalo County. Doctor Bachhuber replaces E. A. Meili, MD,* Cochrane, who resigned because of ill health. Doctor Bachhuber is a graduate of the University of Wisconsin Medical School and has been located in Alma since 1936.

Governor to Talk on Air Conservation

A major step toward fulfilment of his inaugural pledge to "improve the quality of life" for the citizens of Wisconsin will be taken by Governor Patrick J. Lucey at the 1971 annual meeting of the Wisconsin Tuberculosis and Respiratory Disease Association.

The Governor will make a major address to the luncheon session of the meeting, scheduled for Friday, April 2, at the Pfister Hotel in Milwaukee.

The daylong conference, running from 8:45 a.m. to 4:45 p.m., is billed as Wisconsin's first statewide seminar focusing on the subject of air conservation.

Experts from around the nation, as well as from within the state, will exchange ideas in a learning experience designed to "clear the air" surrounding some of the whys, whats, and hows of effective community action for clean air in the 1970s.

The Wisconsin Thoracic Society will hold its annual meeting at the Pfister on Saturday, April 3, from 9 a.m. to 1 p.m.

Mt. Sinai Nursing School to Close

Plans for discontinuing the operation of its Diploma School of Nursing were announced recently by Mount Sinai Medical Center of Milwaukee.

No freshman class will be admitted this year but the 57-year-old program will be maintained until graduation of the present freshman class in June 1973.

The closing follows a nationwide pattern. Nursing students increasingly are turning to the colleges and universities offering baccalaureate and associate degrees after two to four years of study.

"We believe that we can best serve the community by using our facilities to provide clinical experience for the increased number of nursing students in this area," Harry J. Plous, president, and Joseph E. Rapkin, chairman of the board, stated in their joint statement announcing the closing.

Mount Sinai already is affiliated with the Milwaukee Area Technical College which offers a two-year associate degree program. Students will be assigned to specific patient care units at the Center to gain practical experience as part of course work.

An orderly transition is being outlined by the Center after consultation with the Wisconsin State Board of Nursing through Miss Adele Stahl, secretary.

State Heart Group Tops $1 Million in Contributions

Wisconsin Heart Association was one of 13 affiliates of the American Heart Association to exceed $1 million in contributions to the 1970 Heart Fund, it was recently announced by Paul Haberland, PhD, Appleton, 1971 Wisconsin Heart Fund chairman.

The national association had a total of $43,938,370 in public contributions in 1970, an increase of almost $3 million over 1969.

Approximately $12 million was received on Heart Sunday, February 22, 1970, by more than 2,000,000 volunteers who called on their neighbors for donations. Citizens of Wisconsin contributed $285,960 during that campaign.

The 1971 Heart Fund campaign is being held nationwide throughout February, designated by Congressional Resolution as "Heart Month."

A 1971 goal of $870,000 has been set by the WHA to be raised during the campaign. Fund-raising activities will culminate on Heart Sunday, February 21, when more than 25,000 volunteers will canvass the state for contributions.

AAAM Elects Dr. J. L. Weygandt to Office

The American Association for Automotive Medicine, during its 14th annual conference recently, elected James L. Weygandt, MD,* Sheboygan Falls, as secretary of the association. Doctor Weygandt serves on the Wisconsin Advisory Council on Highway Safety, is a member of the President's Committee on Highway Safety, and is Chairman of the State Medical Society's Commission on Safe Transportation.

Hania W. Ris, MD*

. . . Madison pediatrician, recently was elected a member of the Ambulatory Pediatric Association which has over 400 members nationally. The Association's aims are to encourage the development of theoretical and practical knowledge, to exchange new ideas, and to discuss mutual problems among those whose primary concern is teaching, research, and care in relation to the ambulatory patient. Doctor Ris is medical director of the Wisconsin School for Girls and is in the private practice of pediatrics and adolescent medicine as well as being on the clinical faculty in the Department of Pediatrics of the University of Wisconsin Medical School.

J. Richard Schroder, MD*

. . . Janesville, recently was elected chief of staff of the Mercy Hospital medical staff. Gerald P. Gredler, MD,* F. R. Russo, MD,* and R. L. Kochell, MD,* were named president, president-elect, and secretary–treasurer, respectively.

Gerald E. Porter, MD*

. . . Marshfield, recently was elected president of the medical staff of St. Joseph's Hospital, Marshfield. Other new officers are MDs William V. Dovenbarger,* vice-president; William M. Toyama,* secretary; George L. River* and Raymond E. Burrill* were elected at-large members of the hospital medical executive committee.

William Merchant, MD

. . . director of the Veterans Administration Hospital in Madison, recently was featured in "Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Merchant, a graduate of Columbia Medical School, has held the post of director for the last three years.

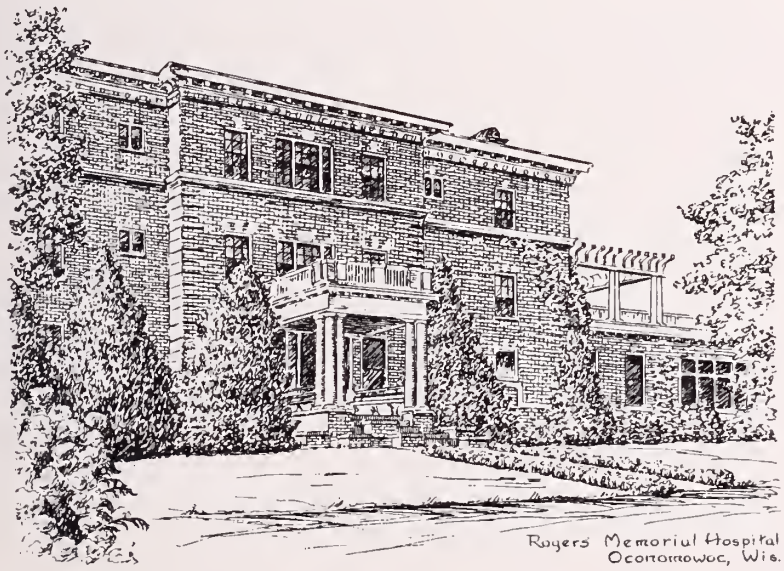
Philip M. Marden, MD*

. . . Oconomowoc pediatrician and Kenneth J. Winters, MD,* Wauwatosa, recently participated in a panel discussion on child abuse. The conference was sponsored by the Wisconsin Association for Retarded Children.

Dr. Ruppenthal Dr. Skemp

George E. Skemp, MD*
Karl P. Ruppenthal, MD*

. . . La Crosse County physicians, recently were honored for "service to the community and St. Francis Hospital" at a meeting of the hospital's medical staff. Their combined years of medical practice total almost 90. They are both graduates of Marquette University School of Medicine. Doctor Skemp is associated with the Skemp Clinic in La Crosse and Doctor Ruppenthal has been in practice in Bangor and associated with St. Francis Hospital for 44 years.



MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF FEBRUARY 1971

1 State Pharmacy Board Exams
1 Joint Meeting of Madison Hospitals Infection Committees
1 Dane County Medical Society Board of Censors
2 Madison General Hospital Surgical Staff
2 Madison Urological Society
2 Madison Anesthesiology Society
2 Dane County Medical Society Board of Trustees
4 SMS Division on School Health
4 Workshop on Utilization of Educational Media for Health Sciences, University of Wisconsin–Madison School of Nursing
10 Steering Committee, Wisconsin Regional Medical Program
10 Legislative Committee, Wisconsin Association of Professions
11 Conference on the Physician Assistant
11 SMS Commission on Hospital Relations and Medical Education
12 Symposium for Registered Nurses and Dietitians on Techniques of Teaching with Heart, Dane County Unit, Wisconsin Heart Association
13 Wisconsin College Health Association
14 SMS Division on Nervous and Mental Diseases
15 Dane County Medical Society Insurance Advisory Committee
18 Wisconsin Otolaryngological Society
18 Executive Committee, SMS Commission on Medical Care Plans
19 Wisconsin Otolaryngological Society
24 Health Careers Program Advisory Committee, Wisconsin Health Council
24 Board of Directors, Wisconsin Health Council
24 Conference with Representatives of Wisconsin Association of Podiatrists
25 Wisconsin Regional Medical Program Staff
25 Conference on Obstetrical Departments of University Hospitals and Madison General Hospital
25 Advisory Committee on Utilization Review Programs
27 Executive Committee of SMS Council

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

CONTRIBUTIONS—CES FOUNDATION

January 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for January 1971:

Nonrestricted

The Monroe Clinic	Contribution
Dr. & Mrs. J. C. Fox, E. J. Nordby, MD & Wisconsin Physicians Service	Memorial: A. J. McCarey, MD
Margaret K. Pharo, LaVonne S. Beale	Memorial: Lt. Col. John R. Tesch
R. M. Hammer, MD	Memorial: Mrs. Margaret Kealy
Langlade County Medical Society	Memorial: Geo. E. Moore, MD
Walter C. Rattan, MD	Memorial: James Lutz, MD
E. J. Nordby, MD	Memorial: Corwin Shell
LaCrosse Clinic, Ltd. Staff	Memorial: Gregory Hickey
State Medical Society	Memorials: M. J. Werra, MD, J. G. Hirschboeck, MD, C. F. Dunn, MD, V. E. Ekblad, MD, L. H. Sieb, MD, T. H. Rolfs, MD, G. W. Dean, MD, W. T. Lindsay, MD, & J. E. Bentley, MD (nonmember)

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorials: Mrs. Ben Valenza & A. J. McCarey, MD

Museum of Medical Progress

Mrs. Helen V. Krueger, Dr. & Mrs. John Ford, Mr. & Mrs. Frederick Baer, Mrs. Mabel Weise, Mrs. Currie E. Witteborg, Mr. & Mrs. Donald Shuster, Dr. & Mrs. R. L. Troup, Dr. & Mrs. Loren Hart, Mr. James B. McKanna, Dr. & Mrs. Robert Wochos, Mr. & Mrs. James Everson, Mr. & Mrs. Frederic Burrall, Mr. & Mrs. F. J. Lenfesty, Mr. & Mrs. Thomas Hundley, Mr. Jerry R. Atkinson, Mr. & Mrs. Donald Larsen, Dr. & Mrs. Richard L. Myers, Mrs. Mary June White, Dr. & Mrs. L. Milson, Mr. & Mrs. John Rose, Mrs. Robert Burns & Family, Mr. & Mrs. Robert Cowles, Mr. & Mrs. Paul Mincau, Dr. & Mrs. Richard Jensen, Mr. & Mrs. Fred Lindner, Mrs. Edward Bourquignon, Mrs. Michael Skaff, Mr. & Mrs. Edward Ploederl, Mr. James Stathas, Mr. & Mrs. Dominic Olejniezak, Mrs. Leslie Smith, Mrs. A. A. Reimer, Mr. & Mrs. J. A. Neufeld, Mr. & Mrs. Milton Simons, Mr. & Mrs. Carl Mraz, Mr. & Mrs. Carl Witteborg, Mr. & Mrs. F. M. Vander Perren, Mr. Dell McCoy, Mrs. D. F. Gosin, Mr. Bill Nystrom, Dr. & Mrs. Robert Schmidt, Mr. and Mrs. John Bie, Mr. & Mrs. Daniel Beisel, Mr. & Mrs. John Sargent, Mr. & Mrs. Richard Schibly, Mr. & Mrs. Raymond Biebel, Mr. & Mrs. John Martin Kovic, Mr. & Mrs. Larry Gerozak, Mr. & Mrs. Thomas LeCapitaine, Dr. & Mrs. Arthur Vorwald, Mr. & Mrs. Dwight Desalva, Mr. & Mrs. John Torinus, Mrs. Norbert Christman, Mr. & Mrs. Robert Ryan, Mrs. Marge Brogan, Mrs. Burt Kuske, Miss Tiny O'Brien, Mrs. Elizabeth G. Simpson, Mrs. Grace Nowak, Mrs. Gertrude Taylor, Schuldes, Burns, Alk & Denis, & Mr. & Mrs. Robert Hoffman — Memorial: A. J. McCarey, MD

ANNUAL SCIENTIFIC SESSIONS OF

THE WISCONSIN HEART ASSOCIATION

An Appraisal of Coronary Surgery 1971

May 24–26 • Milwaukee

Milwaukee Expo and Red Carpet Inn

Co-sponsored by: Council on Clinical Cardiology and Council on Cardiovascular Surgery, American Heart Association

Program Director: H. David Friedberg, MD

Fond du Lac Physicians Discuss New UW Medical Center Complex with Dean Eichman

AT A RECENT MEETING IN Fond du Lac, University of Wisconsin Medical School Dean, Peter L. Eichman, MD* (seated right), showed plans for the new UW Medical Center Complex in Madison to members of the UW Medical Alumni Association. Seated with Dr. Eichman are Robert E. Cullen, MD,* past president of the Fond du Lac County Medical Society and Norman A. Becker, MD,* host chairman. Standing are Robert F. Schilling, MD, UW professor of medicine, and John R. Renner, MD, director of the UW's family practice program. (Photo courtesy FOND DU LAC COMMONWEALTH REPORTER)

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ANNOUNCING . . . an opportunity for increased benefits through the State Medical Society Life Plan

The State Medical Society of Wisconsin Life Insurance Plan, in successful operation since 1957, has been liberalized a number of times. Now the **coverage available to members has been increased to $50,000** ($75,000 if this amount does not exceed two times the member's annual earnings).

The State Medical Society has arranged for a **limited enrollment** on behalf of its members in order to take advantage of these increased benefits. Details will be sent to members soon by mail.

OUTSTANDING BENEFITS: ■ Individual non-cancellable protection at minimum cost ■ Premium rates guaranteed ■ Premiums based upon age last birthday ■ Accidental Death Benefit at no extra cost ■ Guaranteed conversion privilege at any time, prior to age 70 ■ Ownership is transferable

The State Medical Society continues to recommend this plan as one of the very best available

ADMINISTRATOR: Ralph L. Reed, C.L.U.
Suite 757 Marine Plaza
111 E. Wisconsin Avenue
Milwaukee, Wisconsin 53202
Phone: 414/276–3576

THE BANKERS LIFE
HOME OFFICE: DES MOINES, IOWA

Angelita D. Carencia, MD

. . . Tomah, recently joined the medical staff at the Tomah Veterans Administration Hospital. Doctor Carencia graduated from the University of Santo Tomas, Manila, The Philippines, and completed her internship at St. Vincent Hospital in Worcester, Mass. Her residency was completed in the New York City Infirmary, Harrisburg, Pa., Presbyterian Hospital, Philadelphia, and St. Joseph Hospital in Long Island, N. Y. Doctor Carencia had cardiology training at Brooklyn Hospital and Mt. Sinai Hospital in New York and at St. Joseph Hospital in Toronto, Canada. She also completed a residency in pediatrics followed by pediatric cardiology at Victoria Hospital, London, Canada. She was a consultant in pediatrics and internal medicine in Guam Memorial Hospital and was chief of crippled children's services, Department of Public Health and Social Services, in Guam.

G. Daniel Miller, MD*

. . . Oconomowoc, and his family recently were honored by the Town and Country WMCA as the "Family of the Year." □

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Discuss Comprehensive Health Care

Representatives of the state's Blue Cross and Blue Shield health insurance programs met with the Jefferson County Health Resource Committee of the Health Planning Council, Inc. of Madison, February 3, in Jefferson.

The meeting, which was open to all interested persons, centered around "Health Insurance, Past and Future."

Howard Brower, associate secretary of the State Medical Society of Wisconsin, explained the Society's insurance program which is conducted by WPS—Wisconsin Physicians Service-Blue Shield.

Representing Blue Cross of Wisconsin was Robert Haskins, vice-president for professional relations, of Milwaukee.

Both men mentioned that their organizations are presently experimenting in various ways with insurance coverage in an attempt to meet the challenges posed by the problems of today's health-care delivery costs and of the accessibility of such care.

During the discussion the question was raised concerning the desirability of adopting a code of ethics for all health insurance representatives and of standardizing insurance claim forms. Group health insurance coverage, rather than individual, was stressed both from the cost-saving factor and the benefits.

In a discussion of cutting costs of health care, it was pointed out that there is too much duplication of facilities and services within a given area. Combining services such as those of laboratories, x-ray departments, and maternity departments as well as other medical services, could result in an estimated 25 percent reduction in cost to the patient.

However, it also was stressed that such combining efforts would require the all-out support of the public which has become used to the supposed or real convenience of all services being provided locally.

Presiding at the discussion session was Paul R. Glunz, MD* of Beaver Dam, chairman of the Jefferson County Health Resource Committee which is a part of Southern Wisconsin's eleven-county health planning agency, the Health Planning Council, Inc. of Madison.

Dr. Shealy, La Crosse, Honored by St. Paul Surgical Society

C. Norman Shealy, MD,* chief of neurosurgery at the Gundersen Clinic, La Crosse, recently was voted an honorary member of the St. Paul Surgical Society. He was the invited guest lecturer for the annual meeting and he spoke on the "Current Status of the Control of Pain in the Human Body."

In 1965, while assistant professor of neurosurgery at the Western Reserve University, Cleveland, Doctor Shealy theorized that electronic impulse generators might be implanted in human beings for the purpose of stimulating the dorsal column fibers of the spinal cord, resulting in the relief of pain. The new procedure, named electroanalgesia, was first performed by Doctor Shealy in 1967, and 23 neurosurgeons throughout the country have installed the stimulator in 125 patients.

Blood Storage Research In Milwaukee Funded

The Medical College of Wisconsin and The Milwaukee Blood Center announced recently that they had received a one-year grant of $116,690 to fund a cooperative research project to determine better storage methods for blood platelets.

The grant is one of four provided to U.S. blood research centers by the National Blood Resources Program of the National Heart and Lung Institute.

Milwaukee is just meeting its most critical demands for platelets. Approximately 1600 units of platelet concentrate are administered in Milwaukee yearly whereas at least 3200 units would be used if that amount were available, according to Blood Center director, Richard H. Aster, MD.*

Gary Becker, MD, assistant director of the Blood Center, and an MCW assistant professor of medicine, is a co-principal investigator with Dr. Aster. □

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF JANUARY 31, 1971

NEW MEMBERS

Brick, Daniel L., 206—6th Ave., West, Ashland 54806
Diancin, Renato C., 144 West Madison St., Waterloo 53594
Dixit, Ameer M., 113—3rd St., Watertown 53094
Frisbie, James H., 630 South Central Ave., Marshfield 54449
Quanbeck, David T., 418 East Water St., Watertown 53094
Smullen, William A., 630 South Central Ave., Marshfield 54449
Subapodok, Charungsang, 630 South Central Ave., Marshfield 54449
Swanson, Philip A., 715 South Barstow St., Eau Claire 54701
Vergara, Victor G., Jr., 442—2nd St., Reedsburg 53959

CHANGE OF ADDRESS within a city

Albright, John G., 1912 Atwood Ave., Madison 53704
Alverno, Luca, 9191 Watertown Plank Rd., Milwaukee 53226
Ancheta, Valantino S., 375 Greenfield Ave., Algoma 54201
Bliwas, Arnold, 1000 Mayfair Dr., Racine 53402
Brown, Jack D., 202 South K, Sparta 54656
Collins, Richard A., 8901 West Lincoln Ave., Milwaukee 53227
Cron, Roland S., 7740 North River Edge Dr., Milwaukee 53209
Felton, Owen L., USAF Medical Center (HSL), Wright–Patterson AFB, Ohio 45433
Ferrou, Carlos A., 3048 North Downer Dr., Milwaukee 53211
Fischer, William A., Frederic 54837
Gargas, Bruce L., 400 East Thomas St., Wausau 54401
Gettelman, Sydney T., 7635 West Oklahoma Ave., Milwaukee 53219
Glenn, Everett C., Medical Arts Bldg., Port Edwards 54469
Gordon, John J., 1176 New York Ave., Oshkosh 54901
Gueldner, Louis H., 332 Merchants Ave., Fort Atkinson 53538
Hill, Nels A., 4032 Mandan Circle, Madison 53711
Hinson, Robert E., 6530 North Pine Shore Dr., Milwaukee 53209
Hyslop, Volney B., 5818 West Valley Forge Dr., Milwaukee 53213
Kelble, John A., 201 East Fox Dale Rd., Milwaukee 53217
Kurtz, Esther C., 1691 Beach Park Blvd., Foster City, Calif. 94404
Lucas, George L., 6642 Gettysburg Dr., Madison 53705
MacMillan, David G., Route #1, Barron 54812
Nemeth, Charles, 1009 North Jackson, Milwaukee 53202
Nereim, Theodore J., 704 View Court, Mount Horeb 53572
Peters, Howard R., 645 Brevoort Lane, Green Bay 54301
Plautz, Arthur C., Jr., 2203 South River Rd., Janesville 53545
Pollard, Randall E., 2411 West Capitol Dr., Milwaukee 53206
Sable, Morris H., 425 East Wisconsin Ave., Milwaukee 53202
Sella, John L., 6114 West Capitol Dr., Milwaukee 53216
Sorenson, Robert I., 3615 West Oklahoma Ave., Milwaukee 53215
VanGemert, John G., 2710 Van Hise Ave., Madison 53705
Viernes, Patricio F., 8430 West Capitol Dr., Milwaukee 53222

CHANGE OF ADDRESS from city to city

Chelius, Carl–Juergen, Cudahy, to 3533 East Ramsey Ave., Milwaukee 53221
Cornell, John W., Cudahy, to 3533 East Ramsey Ave., Milwaukee 53221
Fine, Jacob M., Cudahy, to 3533 East Ramsey Ave., Milwaukee 53221
Giminez, Jose L., Milwaukee, to 5900 South Lake Dr., Cudahy 53110
Hirschler, Charles W., Madison, to Route #1, Cross Country Trail, Verona 53593
Holder, Donald H., Green Bay, to 5670 East State St., Rockford, Ill. 61101
Kerrihard, George N., Madison, to 7677 Sabino Vista, Tucson, Ariz. 85715
Kratochvil, Clyde H., Kalamazoo, Mich., to 6403 Liteolier St., Portage, Mich. 49081
Lando, David H., Jr., Cudahy, to 3533 East Ramsey Ave., Milwaukee 53221
Larson, Arthur N., Cincinnati, Ohio, to 4200 West 3rd St., Dayton, Ohio 45428
Liu, Cheng–Chi, Milwaukee, to 6080 South 108th St., Hales Corners 53130
McCormick, Glen E., Milwaukee, to 890 Elm Grove Rd., Elm Grove 53122
Nock, Gilbert J., Jr., Milwaukee, to Route #1, Box 75, Belgium 53004

DEATHS

Smyth, I. P., nonmember, Dec. 8, 1970
Thompson, Roland, nonmember, Dec. 23, 1970
Lutz, James J., Kenosha County, Jan. 9, 1971
McCarey, Arthur J., Brown County, Jan. 9, 1971
Moore, George E., Langlade County, Jan. 12, 1971
Creasy, Leurner E., Green County, Jan. 15, 1971
Haines, Brunetto J., Chippewa County, Jan. 20, 1971
Stoops, Charles W., Dane County, Jan. 30, 1971 □

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

REPORT ON THE XYY CHROMOSOMAL ABNORMALITY

National Institute of Mental Health, Center for Studies of Crime and Delinquency. 5454 Wisconsin Ave., Chevy Chase, Md. 20015. Oct. 1970, U. S. Department of Health, Education, and Welfare. 55 pages

COGNITIVE AND MENTAL DEVELOPMENT IN THE FIRST FIVE YEARS OF LIFE

National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20015. Nov. 1970. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 111 pages. Price: 55¢

ACOUSTICS TECHNOLOGY—A SURVEY

National Aeronautics and Space Administration. By Skipwith W. Athey, PhD. 1970. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 139 pages. Price: 65¢

DIGEST—EMERGENCY HEALTH SERVICE

U. S. Department of Health, Education, and Welfare—Division of Emergency Health Services. 1970. Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402. 135 pages. Price: 50¢ □

OBITUARIES

Ivor Patrick Smyth, MD, 47, Manchester, Conn., died Dec. 8, 1970, in Manchester.

Doctor Smyth was born in Londonderry, Northern Ireland, and came to this country in 1955. He graduated from the Medical School of University College of Dublin. He was an assistant professor of radiology at the University of Minnesota and a fellow in radiology at Yale University. Doctor Smyth was head radiologist at Windham Community Memorial Hospital, Willimantic, Conn. He practiced at St. Mary's Hospital, Madison, from 1959–1961.

Surviving are his widow; and four daughters, Deara, Tresi, Megan, and Mavra; and three sons, Colin, Ronan, and Conor, all of Manchester.

John E. Bentley, MD, 77, former team physician for the University of Wisconsin athletic teams for 25 years, died Dec. 22, 1970, in Madison.

Born on March 1, 1893, in Portage, Doctor Bentley graduated from the University of Pennsylvania Medical School in 1917 and served his internship at St. Luke's Hospital, Chicago.

Doctor Bentley served in World War I and returned to Portage where he was in general practice and the city health officer. In 1936, he joined the University of Wisconsin faculty and was also the associate director of the student health department until his retirement in 1963. Doctor Bentley was a medical officer during World War II serving in the South Pacific with the 44th General Hospital unit.

He was a former member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Edith; a daughter, Mrs. Bryard L. Giroulx, Wausau; two sons, John E., Seattle, Wash.; and Frederick, Walnut Creek, Calif.

Louis H. Sieb, MD, 64, Seymour, died Dec. 23, 1970, in Seymour.

Born on Dec. 30, 1905, in Indiana, Doctor Sieb graduated from the Northwestern University Medical School in 1932 and served his internship and residency at Wesley Memorial Hospital, Chicago, Ill. He had been associated with the Hittner Clinic, Seymour, since 1932.

Doctor Sieb was a member of Brown County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Elizabeth; and one son, Donal, Madison.

Roland Lewis Thompson, MD, 77, Burbank, Calif., died Dec. 23, 1970, in Burbank.

Born on Mar. 9, 1892, in Mauston, Doctor Thompson graduated from the University of Wisconsin and received his medical degree from the Northwestern University Medical School in Evanston, Ill. He studied in Vienna, Austria, and Edinburgh, Scotland. In 1921, he began his practice in Burbank, Calif., and for the next 44 years practiced in Burbank, Glendale, and the Los Angeles area. He was on the surgical staff of the Hollywood Presbyterian Hospital for over thirty years, and also had been on the staff of the Los Angeles County General Hospital and the Glendale Memorial Hospital.

Since his retirement in 1965, Doctor Thompson spent considerable time on his farms in Hillsboro Township, west of Elroy.

Surviving are his widow, Dagney; and one daughter, Barbara (Mrs. G. Mueenuddin), Lahore, West Pakistan.

Arthur J. McCarey, MD, 82, prominent Green Bay physician died Jan. 9, 1971, in Green Bay.

Born on Sept. 9, 1888, in Antigo, Doctor McCarey graduated from Rush Medical College in 1912 and served his internship at the Hospital of St. Anthony de Padua, Chicago. Doctor McCarey served in World War I, from 1917–1919, and was cited by Gen. John Pershing for exceptional meritorious and conspicuous service. He was awarded the Purple Heart after service in the 4th Division in England, France, and Germany.

Doctor McCarey was a founder of the Wisconsin Surgical Society and a member of the American College of Surgeons. He was the first president of the Green Bay Board of Health and was also president of St. Mary's Hospital medical staff and served on the staffs of St. Vincent and Bellin hospitals.

Active in the affairs of the State Medical Society of Wisconsin, he was a councilor from the 6th district from 1949–1954 when he was elected president of the Society. He was instrumental in establishing the Museum of Medical Progress at Prairie du Chien and served as the vice-president of the Society's Charitable, Educational, and Scientific Foundation. He was a member of the House of Delegates and also served on the Society's committees on Hospital Relations, Medical Economics, and Medical Care Plans.

Doctor McCarey also was a member of the Brown County Medical Society and the American Medical Association.

Surviving are three daughters, Mrs. John Stathas (Betty), Green Bay; Mrs. George Fowler (Kathleen), California; and Mrs. John A. Faas (Patricia), McHenry, Ill.

James Joseph Lutz, MD, 65, Kenosha, died Jan. 9, 1971, in Kenosha.

Born on April 2, 1905, in Des Moines, Iowa, Doctor Lutz graduated from Rush Medical College in 1931. Doctor Lutz started practice at Phelps and operated the only hospital in Vilas County. He moved to Kenosha in 1945.

He was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin, American Medical Association, and American Academy of General Practice.

Surviving are his widow, Louise; and three daughters, Mrs. Walter (Betty) Perls, Glenview, Ill.; Mary of Kenosha; and Martha, Montclair, Calif.

George E. Moore, MD, 80, prominent Antigo physician and surgeon, died Jan. 12, 1971, in Antigo.

Born on April 26, 1890, in Kewaunee, Doctor Moore graduated from the University of Wisconsin College of Agriculture with a BS degree in 1914 and from the Northwestern University Medical School in 1918. He served his internship at King's County Hospital in Brooklyn, New York.

Doctor Moore was a member of the American College of Radiology and a 50-year club member of the State Medical Society of Wisconsin.

He contributed articles and x-ray pictures on bone surgery to medical journals and was frequently quoted in medical textbooks. He also wrote articles for the Eastman Kodak magazine and collaborated with Yale University in x-ray photography.

Doctor Moore was responsible for developing "A Simplified Type of Roentgen Pelvemeter with Mathematical Calculations" (article written with Prof. Skinner, *American Journal of Surgery*, 1932); "Fractures of the Tuber Calcanei Involving the Medial and Lateral Processes," and others.

Doctor Moore served on the surgical staff of Langlade County Memorial Hospital, Antigo, and recently was recognized for his 35 years of association with the hospital. He also served in the United States Navy during World War I.

He also was a life member of the Langlade County Medical Society, and a member of the American Medical Association.

Surviving are his widow, Jessie; and four sons, George, Appleton; Donald, Oshkosh; Frederick, Fond du Lac; and William, Antigo.

Leurner E. Creasy, MD, 90, co-founder of the Monroe Clinic, died Jan. 15, 1971, in Sarasota Fla.

Born on August 20, 1880, in Caldwell, Ky., Doctor Creasy graduated from the Northwestern University Medical School and began his practice in South Wayne. In 1920 he moved to Monroe and engaged in private practice. He co-founded the Monroe Clinic on Jan. 1, 1939. Doctor Creasy was a 50-year club member of the State Medical Society of Wisconsin and was delegate to the Society from Green County from 1937–1945.

He was a member of the Green County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Ledra; and a daughter, Mrs. A. A. (Celia) Bennett, Sun City, Calif.

Brunetto Jerome Haines, MD, 53, Cadott, died Jan. 20, 1971, in Cadott.

Born Sept. 24, 1917, in Arcadia, Doctor Haines graduated from the Marquette University School of Medicine in 1942, then served a one-year internship at St. Francis Hospital, La Crosse.

From 1943–1947 Doctor Haines served as a physician and surgeon with the United States Air Force.

Following postgraduate work in dermatology at Cook County Hospital, Chicago, Doctor Haines practiced in La Crosse. In 1952, he moved to Cadott where he became associated with the Cadott Medical Center. A few years later he opened his own medical center.

Doctor Haines was a past president of St. Joseph's Hospital medical staff and a member of the board, and also was president of the Blood Bank.

In addition to his professional interests, Doctor Haines was active in community affairs including theatrical productions and as a lead singer in a local quartet.

He was a member of the American Academy of General Practice, Chippewa County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Betty; five sons, William, at Marquette University, Milwaukee; John, James, Richard, and Mark, at home; and two daughters, Patricia and Geralyn, at home. Among his four brothers who survive is Marcellus C. Haines, MD of Oshkosh.

Charles W. Stoops, Jr., MD, 53, Madison, died Jan. 30, 1971, in Madison.

Born on Jan. 6, 1918, in Chicago, Ill., Doctor Stoops graduated from the University of Wisconsin Medical School in 1942 and interned at Baylor University Hospital in Dallas, Tex. During World War II, he served with the United States Navy in the South Pacific from 1943–1946, after which he did residency in dermatology at the University of Michigan, Illinois, and University Hospitals in Madison.

Doctor Stoops served on the Council of the State Medical Society of Wisconsin from 1963–1969 and was a former president of Dane County Medical Society. He was a former board member of the Wisconsin Division of the American Cancer Society and was on the Committee on Cancer of the State Medical Society. He was a member of the American Academy of Dermatology, Wisconsin Dermatological Society and American Medical Association.

Surviving are his widow, Eleanor; a son, James, at home; and two daughters, Jane, at home and Barbara, New Haven, Conn. □

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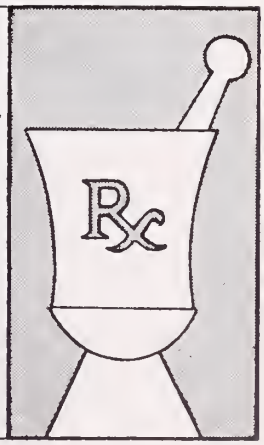

Gone with the wind

the wisconsin medical journal

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MEDICAL MEETINGS

POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Apr. 29: Annual Spring Medical Symposium 1971, Jackson Clinic and Foundation and Methodist Hospital, Madison.

May 3–5: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 8–9: 12th Annual North Central Allergy Society Meeting, Pfister Hotel, Milwaukee.

May 10–12: Annual Meeting, State Medical Society of Wisconsin, Hotel Sheraton–Schroeder and Pfister Hotel, Milwaukee.

May 11–12: Wisconsin Clinic Managers Meeting, Pfister Hotel, Milwaukee.

May 24–26: Annual scientific sessions of The Wisconsin Heart Association—"An Appraisal of Coronary Surgery 1971." Milwaukee Expo and Red Carpet Inn, Milwaukee. Program Director: H. David Friedberg, MD.

Aug. 5–28: Scandinavian/Russian Holiday, Wisconsin Alumni Association. Info: Wisconsin Alumni Tours, 650 N. Lake St., Madison, Wis. 53706.

Sept. 10–11: Annual scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel and Tower, Milwaukee.

Sept. 22: Sixth annual Adolf Gundersen Symposium for Physicians—"Understanding Arrhythmias." Co-sponsored by the Wisconsin Heart Association and the Adolf Gundersen Foundation. Valhalla Hall, Wisconsin State University, La Crosse.

Oct. 17–23: Wisconsin Work Week of Health.

1971 NEIGHBORING STATES

May 5–8: *Fractures and Other Trauma,* Chicago Committee on Trauma, American College of Surgeons, John B. Murphy Auditorium, Chicago. Info: ACS, 55 East Erie St., Chicago, Ill. 60611.

May 15: *Seminar in Medical Writing,* Arlington Park Towers Hotel, preceding opening of Illinois State Medical Society annual meeting, Arlington Heights, Ill.

May 16–19: 131st Annual Convention, Illinois State Medical Society, Arlington Park Towers, Arlington Heights, Ill.

May 17–19: Annual Convention, Minnesota State Medical–Association, St. Paul Hilton Hotel, St. Paul, Minn.

May 24–26: *Annual Continuation Course in Surgery,* University of Minnesota, Nolte Center for Continuing Education, Minneapolis, Minn. 55455.

May 24–28: *Clinical Endocrinology—Physiological Basis for Current Diagnostic and Therapeutic Procedures,* American College of Physicians, University of Michigan Medical Center, Ann Arbor, Mich.

June 16: *Symposium on Genetic Counseling,* presented by Children's Memorial Hospital, Chicago; sponsored by The National Foundation–March of Dimes, at Sheraton Chicago Hotel, Chicago. Info: Chicago Chapter–National Foundation, 173 West Madison St., Chicago, Ill. 60602.

Summer: *1971 North Michigan Summer Course,* University of Michigan Department of Postgraduate Medicine, Traverse City at Shanty Creek Lodge, Bellaire. Info: U–M Dept of PG Med, Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48104.

Sept. 13.–15: *Clinical Electroencephalography.* American Electroencelphalographic Society, in Minneapolis, Minn. Info: Donald W. Klass, MD, EEG Course Dir., Mayo Clinic, Rochester, Minn. 55901.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

1971 OTHERS

May 1–2: 19th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists, Civic Auditorium, San Francisco, Calif. Info: Donald F. Richardson, 79 West Monroe St., Chicago, Ill. 60603.

May 7–9: Medical Legal Conference, American College of Legal Medicine, Royal Orleans Hotel, New Orleans, La. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

May 10–12: Annual Meeting, American College of Sports Medicine, Toronto, Canada. (Exec. Secy.: Mr. Donald E. Herrmann, 1440 Monroe St., Madison, Wis. 53706; tel.: area code 608/262–3632)

May 12–13: *Advances in Dermatology,* Cleveland Clinic Educational Foundation, 2020 East 93rd St., Cleveland, Ohio 44106.

May 17–19: Second National Conference on Breast Cancer, American Cancer Society, Century Plaza Hotel, Los Angeles, Calif.; info: Esther Kelley, Professional Education, ACS, Inc., 219 East 42nd St., New York, N.Y. 10017.

May 19–21: Annual "Topics in Internal Medicine" course, University of Florida College of Medicine, Gainesville.

May 24–26: Pharmaceutical Manufacturers Association, annual convention, White Sulphur Springs, W. Va.

May 24–25: Fifth Postgraduate Course in the "Care of Spinal Cord Injury Patients," Veterans Administration Hospital, Long Beach, Calif. Applications to: Dr. Erich G. Krueger, Director of Spinal Cord Injury Service (127), VA Central Office, 810 Vermont Ave., N.W., Washington, D.C. 20420, before April 1.

June 7–11: Annual convention, Catholic Hospital Association, Atlantic City, N.J.

June 7–11: *Internal Medicine: Clinical Problems, 1971.* American College of Physicians, University of Cincinnati Medical Center, Ohio. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

June 21–26: Annual General Practice Review, University of Colorado School of Medicine, Estes Park.

June 28–July 2: *Advances in Internal Medicine: Recent Perspectives.* American College of Physicians, University of Alberta Medical School at Edmonton, and the University of Calgary Medical School, to be presented at the Banff School of Fine Arts, Banff, Alberta, Canada. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

July 5–8: *Ophthalmology.* University of Colorado School of Medicine, Colorado Springs.

July 11–14: *Pediatrics.* University of Colorado School of Medicine, Aspen.

July 11–22: *Summer Program in Human Sexuality.* Lecture courses with special reference to the medical aspects of human sexuality, workshops in sex education and counseling, small group discussions. $325, includes housing. Registration ends May 30. Write: Summer Program, Institute for Sex Research, Indiana University, Bloomington, Ind. 47401.

July 20–24: *Internal Medicine.* University of Colorado School of Medicine, Estes Park.

July 22–23: Second annual *Seminar in General Surgery,* Colby College, Waterville, Maine. Info: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.

July 26–29: *Recent Advances in Rheumatic Diseases.* American College of Physicians and University of Colorado School of Medicine, Estes Park.

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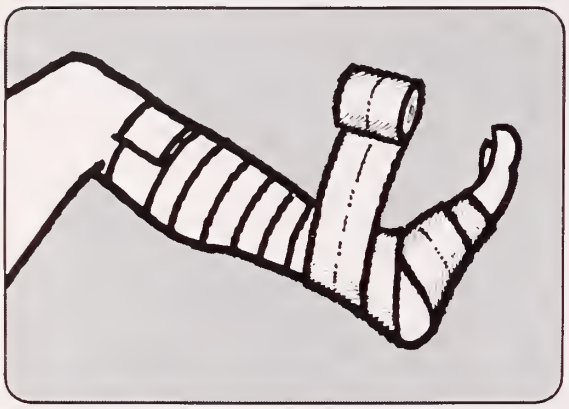

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July 29–31: *Chronic Inflammatory Diseases of the Gut,* American Gastroenterological Association, Aspen, Colo. Info: Mrs. Bernie C. Kern, 740 Krameria St., Denver, Colo. 80220.

Sept. 27–Oct. 1: *Hospital Medical Staff Conference,* University of Colorado School of Medicine, Estes Park.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Oct. 5–7: *18th Spinal Cord Injury Conference.* Joint meeting of Veterans Administration Department of Medicine and Surgery and International Medical Society of Paraplegia, Children's Hospital Medical Center, Boston, Mass.

Nov. 15–18: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, 307 No. Charter St., Madison, Wis. 53715)

Nov. 17–19: Annual Conference, National Society for the Prevention of Blindness, Inc., The Roosevelt Hotel, New York City. (Papers, panel discussion and seminars on the latest developments in detecting and combating potentially blinding eye disease, community-action eye health programs, and programs for industrial and school safety.)

1971 AMA

June 20–24: AMA Annual Session, Atlantic City, N.J.

Aug. 30–31: Congress on Occupational Health, Jackson Lake Lodge, Wyoming.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

For listing of other meetings see the **Journal of the American Medical Association.**

Annual Spring Medical Symposium—Madison

Presented by the Jackson Clinic and Foundation and Methodist Hospital. Thursday, Apr. 29, 1971 at Methodist Hospital. Registration begins 9:30 a.m. with symposium at 10:00. Premiere color film on Methodist Hospital on "Coronary Reconstructive Surgery" produced by Methodist Hospital. Further info: William B. Parsons, Jr., MD, Jackson Clinic.

Trauma Course—Chicago

Professor Gerhard Küntscher of Slensburg, Germany, will be the special guest of the Chicago Committee on Trauma, American College of Surgeons, for its Fifteenth Annual Postgraduate Course on Fractures and Other Trauma.

Professor Küntscher will cover intramedullary fixation in fresh fractures and non-unions, and will speak on osteotomies and bone healing.

The course will be held May 5–8 at the John B. Murphy Auditorium, 50 East Erie Street, Chicago, Ill.

Traditional luncheons at the Kungsholm Restaurant and Reception at the Drake Hotel will be included in the tuition fee of $110.

Registration to: James P. Ahstrom, Jr., MD, Chairman, Trauma Course, 55 East Erie Street, Chicago, Ill. 60611.

Continuation Course in Surgery—Minneapolis

An annual continuation course in surgery, designed primarily for surgeons, will be held May 24–26 at the University of Minnesota, Nolte Center for Continuing Education, Minneapolis, Minn. 55455. It will deal with surgery of the breast and surgery of the endocrine glands.

Seminar in Medical Writing—Arlington Heights

A "Seminar in Medical Writing" will be held Saturday, May 15, at the Arlington Park Towers Hotel preceding the annual meeting of the Illinois State Medical Society, which opens in Arlington Heights May 16.

The all-day seminar, which starts at 9:00 a.m., is sponsored by the Greater Chicago Chapter of the American Medical Writers Association with the cooperation of the Illinois State Medical Society.

A fee of $35 will be charged.

The seminar, aimed primarily at the physician–writer, will consist of a series of roundtable discussions on basic writing techniques and how to prepare copy for publication. Work assignments will be sent to each of the registrants in advance of the seminar.

To register, checks should be sent payable to the Greater Chicago Chapter, American Medical Writers Association, to President Robert E. Dunbar, Suite 1630, 211 E. Chicago Avenue, Chicago, Illinois 60611.

Continuing Medical Education Program—Illinois

A unique continuing medical education program will be featured at the Illinois State Medical Society's 131st annual meeting at the new Arlington Park Towers Hotel in Arlington Heights May 17–19.

Experts in 36 different areas of medicine will discuss topics ranging from "How to Set Up an Anti-Smoking Clinic" to "Management of VD." Other topics include the role of pacemakers, current therapy for burns, drug reactions, dialysis in renal problems, hypertension and the late onset of diabetes.

Physicians will receive credit for the courses from the American Medical Association and The Academy of Family Practice. Advance registration is required.

Physicians also will have an opportunity to match wits with a computer during an unusual self-testing program. The program, developed by the Illinois Regional Medical Program and the University of Illinois Center for Educational Development, incorporates computerized clinical problems.

Physicians desiring further information should contact Perry Smithers, Convention Manager, ISMS, 360 N. Michigan Avenue, Chicago, Illinois 60601.

Seminar in General Surgery—Maine

The second annual seminar in General Surgery will be held at Colby College, Waterville, Maine, July 22–23.

The seminar, given in an informal atmosphere by a distinguished faculty, will concern itself in areas of management of trauma, vascular disease, breast disease, and problems of the biliary tract. It should appeal to practicing physicians and surgeons, residents and recent graduates of residency programs.

For further information, write: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901. □

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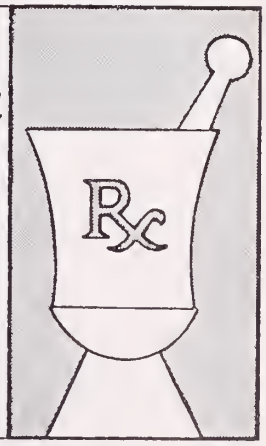

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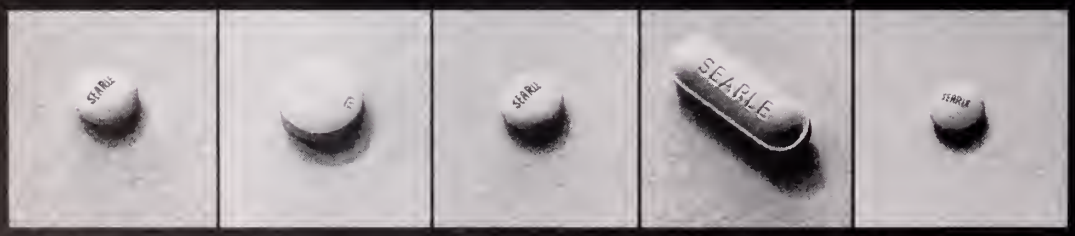

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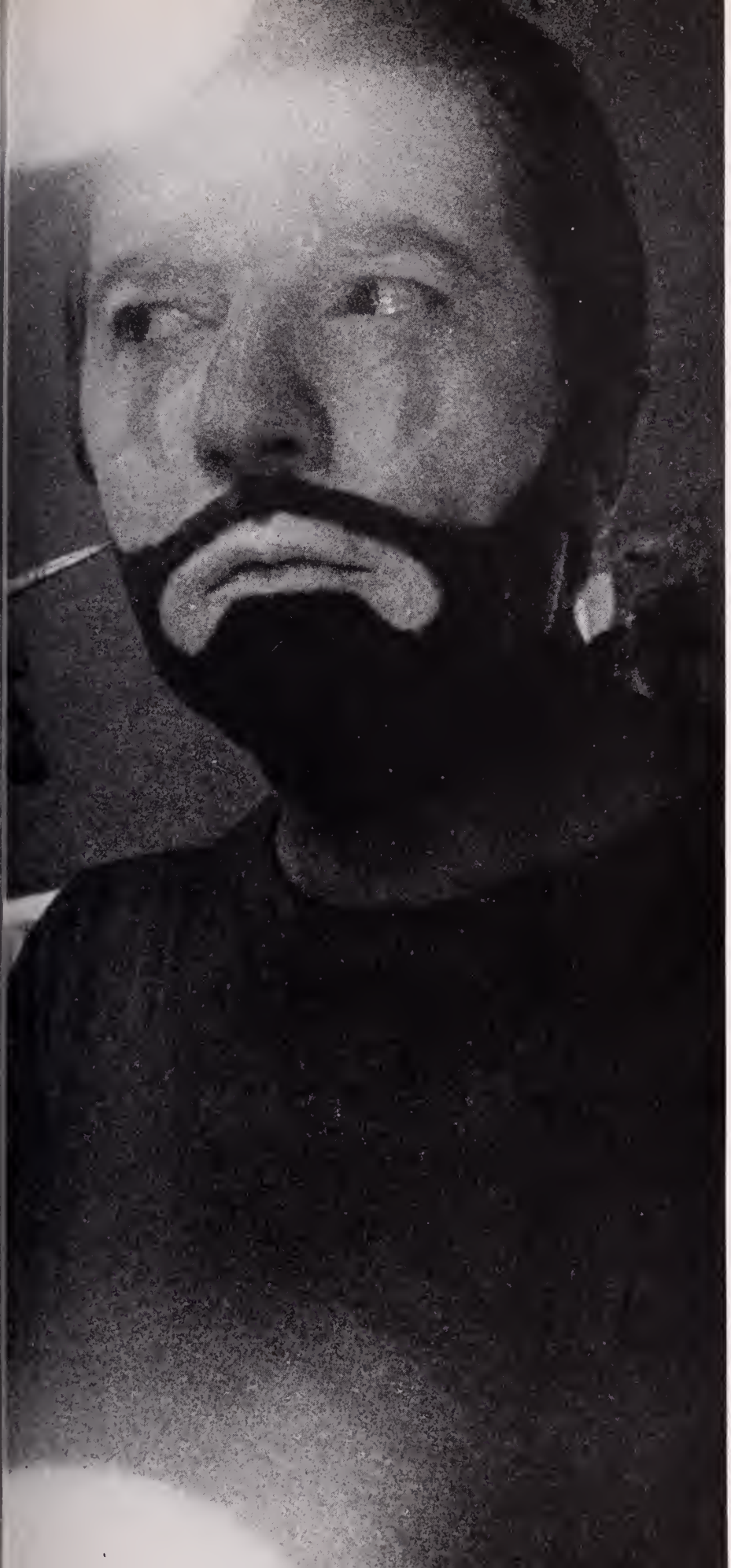
Pro-Banthine 7½ mg. propantheline bromide Half Strength



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Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthine is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

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(thiopropazate dihydrochloride)

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Side Effects: Dryness of the mouth, mydriasis, hesitancy of urination; less commonly extrapyramidal (restlessness, dystonia and signs of pseudoparkinsonism such as muscular rigidity, fixed facies, tremor, ataxia, festinant gait and drooling), parasympatholytic (blurred vision, xerostomia, hypotension, nasal congestion and constipation) and curare-like (loss of control of voluntary muscles, particularly the muscles of respiration) reactions. Rarely, leukopenia or allergic purpura. A generalized erythematous skin reaction may occur. Side effects characteristic of phenothiazines such as grand mal convulsions, altered cerebrospinal proteins, cerebral edema, potentiation of the effects of atropine, heat or phosphorus insecticides, autonomic reactions, endocrine disturbances, reversed epinephrine effect, hyperpyrexia or pigmentary retinopathy may theoretically occur but have not been reported with Dartal. Severe hypotension following recommended doses occurs more commonly in patients who are also afflicted by other medical disorders such as mitral insufficiency or pheochromocytoma, and particular attention should be paid to such a possibility although this has not been observed with Dartal.

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Warning: May be habit-forming.

For *Indications, Contraindications, Precautions, Side Effects* and *Dosage* see Pro-Banthine. In addition, phenobarbital should be administered with caution to patients with liver disease, mental disturbances or a significant degree of hypoxia.

Pro-Banthine P.A.®
prolonged acting brand of propantheline bromide

For *Indications, Contraindications, Precautions* and *Side Effects* see Pro-Banthine.

Dosage Form: Capsule-shaped, compression-coated, peach tablets of 30 mg. for oral use.

Dosage: The recommended initial dosage is one tablet in the morning and one at night.

084

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1971 ANNUAL MEETING

State Medical Society of Wisconsin

Business Sessions
MAY 8 · 11

Scientific Sessions
MAY 10 · 12

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(Scientific Sessions)
(Scientific & Technical Exhibits)

A complete Annual Meeting Program is being sent to all members—watch for it in the mail! A few of the highlights appear on the following pages. Other highlights also appeared in the March issue.

BUSINESS AND RELATED ACTIVITIES at Annual Meeting

- **COUNCIL (Pfister Hotel)**
  - Executive Committee Luncheon—Sat/May 8/12 noon
  - Executive Committee Meeting—Sat/May 8/2 pm
  - Dinner—Sat/May 8/5:30 pm
  - Meeting—Sat/May 8/7 pm
  - Meeting—Tues/May 11/10:30 am
  - Luncheon—Tues/May 11/12:30 pm

- **HOUSE OF DELEGATES (Pfister Hotel)**
  - Section Delegates Caucus—Sun/May 9/10:30 am
  - Registration, 1st Session—Sun/May 9/1 pm
  - First Session—Sun/May 9/2 pm
  - Buffet Supper—Sun/May 9/5:30 pm
  - Reference Committees—Sun/May 9/7:30 pm
  - Nominating Committee—Mon/May 10/3 pm
  - Registration, 2nd Session—Mon/May 10/6 pm
  - Second Session—Mon/May 10/7 pm
  - Registration, 3rd Session—Tues/May 11/7:30 am
  - Third Session—Tues/May 11/8:30 am

- **OTHERS (Pfister Hotel)**
  - Board of Directors Meeting, Wisconsin Academy of General Practice—Mon/May 10/4 pm
  - PACE Breakfast—Tues/May 11/7:30 am
  - Clinic Managers Luncheon—Tues/May 11/12 noon
  - President's Reception—Tues/May 11/6 pm
  - Past Presidents Luncheon—Wed/May 12/12 noon

- **OTHERS (Sheraton–Schroeder Hotel)**
  - Catholic Physicians Guild Breakfast—Mon/May 10/7:30 am
  - Wisconsin Radiological Society Business Meeting—Mon/May 10/4:30 pm
  - Section on Ophthalmology Luncheon and Business Meeting—Wed/May 12/12:15 pm
  - Wisconsin Otolaryngological Society Business Meeting—Wed/May 12/4:15 pm
  - Wisconsin Surgical Society Presidential Address and Business Meeting—Wed/May 12/4:30 pm

- **OTHERS (various locations)**
  - Wisconsin Radiological Society Dinner—Mon/May 10/6 pm/Milwaukee Yacht Club
  - Marquette Alumni Dinner—Tues/May 11/8 pm/Milwaukee Athletic Club
  - Milwaukee Ophthalmological Society Dinner—Wed/May 12/6 pm/University Club
  - Wisconsin Orthopedic Society—Wed/May 12/6:30 pm/University Club
  - Wisconsin Surgical Society—Wed/May 12/6:30 pm/Performing Arts Center

- **AUXILIARY (Pfister Hotel)**
  - Board of Directors Meeting—Mon/May 10/3 pm
  - Dinner—Mon/May 10/7 pm
  - Business Session—Tues/May 11/9:30 am
  - Luncheon—Tues/May 11/12:30 pm
  - Business Session—Wed/May 12/9:30 am
  - Luncheon—Wed/May 12/12:30 pm

OUT-OF-STATE GUEST SPEAKERS and SCHEDULES

FREDERIC C. BARTTER, MD, Chief, Endocrinology Branch, National Heart and Lung Institute, Bethesda, Md.

TUESDAY, MAY 11: 11:00 am—*Osteoporosis, Everybody's Problem;* 12:15 pm—*Chronobiology in Health and Disease*

ARNOLD P. FRIEDMAN, MD, Clinical Professor of Neurology, College of Physicians and Surgeons, Columbia University, New York City

TUESDAY, MAY 11: 3:30 pm—*An Overview of Chronic Recurring Headache;* 12:15 pm—*The Effects of Headache on History*

HARRY S. JACOB, MD, Chief, Section of Hematology and Professor of Medicine, University of Minnesota Medical School, Minneapolis, Minn.

MONDAY, MAY 10: 10:10 am—*Hereditary Spherocytosis, Mechanisms and Treatment;* 12:15 pm—*The Diagnosis of Hemolytic Anemias*

SIMON KRAMER, MD, Professor and Chairman, Department of Radiation Therapy, Thomas Jefferson University Hospital, Philadelphia, Pa.

MONDAY, MAY 10: 2:00 pm—*Radiotherapy of Breast Carcinoma;* 12:15 pm—*Current Concepts in the Treatment of Breast Cancer*

JAMES H. MATTHEWS, MD, Professor of Anesthesiology, University of Minnesota Medical School, Minneapolis, Minn.

WEDNESDAY, MAY 12: 2:00 pm—*Myths to Abandon;* 12:15 pm—*Anesthesia Specialty Board Requirements: Questions and Answers*

JOSEPH H. OGURA, MD, Professor and Head, Department of Otolaryngology, Washington University School of Medicine, St. Louis, Mo.

WEDNESDAY, MAY 12: 2:00 pm—*Reconstruction Head and Neck Flap Surgery;* 12:15 pm—*Conservation Surgery Capsuled*

MILTON ORKIN, MD, Clinical Associate Professor, Department of Dermatology, University of Minnesota Medical School, Minneapolis, Minn.

TUESDAY, MAY 11: 3:30 pm—*The Resurgence of Scabies;* 12:15 pm—*What's New in Dermatology?*

HERBERT E. PEDERSEN, MD, Professor and Chairman, Department of Orthopedic Surgery, Wayne State University School of Medicine, Detroit, Mich.

WEDNESDAY, MAY 12: 2:00 pm—*Civilian Amputation Problem and Its Management;* 12:15 pm—*Mortality and Morbidity Associated with Treatment of Hip Fractures;* evening dinner speaker—*Management of Cervical Spine Injuries*

KENNETH T. RICHARDSON, MD, Professor and Chairman, Department of Ophthalmology, University of Pittsburgh School of Medicine, Pittsburgh, Pa.

WEDNESDAY, MAY 12: 2:00 pm—*Chronic Open Angle Glaucoma: Diagnosis and Therapeutic Decision;* evening dinner speaker—*Medical Therapy of the Glaucomas*

RAYMOND G. SLAVIN, MD, Associate Professor of Internal Medicine, St. Louis University School of Medicine, St. Louis, Mo.

TUESDAY, MAY 11: 2:00 pm—*What's New in Pulmonary Hypersensitivity Diseases?* 12:15 pm—*Enzyme Detergents as a New Cause of Lung Disease*

Scientific Program

Sheraton–Schroeder Hotel

MONDAY, MAY 10

INTERNAL MEDICINE—Morning

PLENARY SESSION—The Spleen, Organ of Mystery—Clinical Concepts and Management

LECTURERS—A. V. Pisciotta, MD, Milwaukee
Richard A. Holmes, MD, Milwaukee
Richard H. Astor, MD, Milwaukee
Harry S. Jacob, MD, Milwaukee
George L. River, MD, Marshfield
Fred A. Schaldach, MD, La Crosse

SCIENTIFIC LUNCHEONS

Internal Medicine/Pathology/Radiology

INTERNAL MEDICINE—Afternoon

Presented by Section on Internal Medicine

LECTURERS—R. F. Schilling, MD, Madison
Richard A. Rudders, MD, Milwaukee
Donald R. Korst, MD, Madison
Edward B. Crowell, Jr., MD, Madison
Lee L. Schloesser, MD, Marshfield
Robert H. Greenlaw, MD, Marshfield

continued on next page

Group therapy

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PATHOLOGY—Afternoon

LECTURERS—A. F. Cafaro, MD, Milwaukee
Ronald R. Martins, MD, Milwaukee
Donald J. Kuban, MD, Milwaukee
Harry F. Weisberg, MD, Milwaukee
Lorraine F. Meisner, PhD, Madison

RADIOLOGY—Afternoon

LECTURERS—Simon Kramer, MD, Philadelphia
Ardow R. Ameduri, Jr., MD, Madison
Albert L. Wiley, MD, Madison
Douglas King, MD, Milwaukee

TUESDAY, MAY 11

GENERAL PRACTICE—Morning

PLENARY SESSION—Problems for Everyone

LECTURERS—C. M. Kunin, MD, Madison
Frederic C. Bartter, MD, Bethesda

SCIENTIFIC LUNCHEONS

Allergy/Dermatology/Internal Medicine
General Practice/Neurology/Surgery

GENERAL PRACTICE—Afternoon

Presented by Section on General Practice

LECTURERS—C. C. Lobeck, MD, Madison
John H. Renner, MD, Madison

NEUROLOGY—Afternoon

LECTURERS—R. F. Daly, MD, Madison
Paul R. Dyken, MD, Milwaukee
George J. Wolcott, MD, Madison
Arnold P. Friedman, MD, New York City
Francis M. Forster, MD, Madison
Harold E. Booker, MD, Madison
Gastone G. Celesia, MD, Madison
Arlene N. Barr, MD, Madison

ALLERGY—Afternoon

LECTURERS—R. G. Slavin, MD, St. Louis
S. Roger Hirsch, MD, Milwaukee
Marshall H. Benner, MD, Milwaukee
Robert M. Heywood, MD, Marshfield

DERMATOLOGY—Afternoon

LECTURERS—H. R. Foerster, Jr., MD, Milwaukee
Thomas W. Luther, MD, Appleton
Frank H. Urban, MD, Wauwatosa
Robert R. Baumann, MD, Monroe
Daniel E. Hackbarth, MD, Milwaukee
David J. Strang, MD, Eau Claire
Leonard S. Markson, MD, Milwaukee
Robert B. Pittelkow, MD, Milwaukee
Milton Orkin, MD, Minneapolis

continued in next column

RESIDENT–INTERN PAPERS —Tuesday Afternoon

This is a competitive program with cosh awards of $100 each for the two winning presentations. One award known as the WILLIAM S. MIDDLETON AWARD and the second as the HARRY BECKMAN AWARD.

Residents, Interns, Trainees, and Fellows from the two Wisconsin medical schools and their affiliated hospitals will present 12 papers limited to 10 minutes each, during the three-hour session.

WEDNESDAY, MAY 12

SURGERY—Morning

PLENARY SESSION—Pulmonary Care As Viewed by the Internist, Surgeon, Anesthesiologist, and Pathologist

LECTURERS—John Rankin, MD, Madison
Claude A. Taylor, Jr., MD, Madison
Paul O. Simenstad, MD, Madison
John P. Wyatt, MD, Winnipeg, Can.
Donald R. Kahn, MD, Madison

SCIENTIFIC LUNCHEONS

Anesthesiology/Ophthalmology/Surgery
Orthopedics/Otolaryngology

ANESTHESIOLOGY—Afternoon

LECTURERS—James H. Matthews, MD, Minneapolis
Joan C. Faust, MD, Madison
Walter C. Bernards, MD, Milwaukee
Timoteo L. Galvez, MD, Madison
Robert F. Brucker, PhD, Madison

OTOLARYNGOLOGY—Afternoon

LECTURERS—J. H. Ogura, MD, St. Louis
John M. Mills, MD, Green Bay
David M. Wineinger, MD, Green Bay
James H. Brandenburg, MD, Madison

OPHTHALMOLOGY—Afternoon

LECTURERS—K. T. Richardson, Jr., MD, Pittsburgh
Harry A. Easom, MD, Milwaukee
Guillermo B. de Venecia, MD, Madison

ORTHOPEDICS—Afternoon

LECTURERS—H. E. Pedersen, MD, Detroit
George L. Lucas, MD, Madison
John M. Jurist, Jr., PhD, Madison
C. Hugh Hickey, MD, Milwaukee
Andrew A. McBeath, MD, Madison

SURGERY—Afternoon

See Annual Meeting Program

RESERVATION FORMS FOR

Noon Scientific Luncheons

NOTE: Attendance Limited! Please list 2 choices for each of the days you make reservations. List in order of preference. $4.00 per luncheon, including gratuities and taxes.

MONDAY, MAY 10

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. INTERNAL MEDICINE: The Diagnosis of Hemolytic Anemias—Harry S. Jacob, MD, Minneapolis
2. INTERNAL MEDICINE: Reactions to Drugs Used in the Treatment of Leukemia and Lymphoma—George L. River, MD, Marshfield
3. PATHOLOGY: Changing Patterns in Laboratory Medicine—Jon V. Straumfjord, Jr., MD, PhD, Milwaukee
4. RADIOLOGY: Current Concepts in the Treatment of Breast Cancer—Simon Kramer, MD, Philadelphia

Name of Leader *Name of Leader*

First Choice: _____ Second Choice: _____

TUESDAY, MAY 11

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. ALLERGY: Enzyme Detergents as a New Cause of Lung Disease—Raymond G. Slavin, MD, St. Louis
2. DERMATOLOGY: What's New in Dermatology?—Milton Orkin, MD, Minneapolis
3. INTERNAL MEDICINE: Bone Marrow Aspiration Biopsy—Anthony V. Pisciotta, MD, Milwaukee
4. GENERAL PRACTICE: Chronobiology in Health and Disease—Frederic C. Bartter, MD, Bethesda, Maryland
5. GENERAL PRACTICE: Current Problems in Antimicrobial Therapy—Calvin M. Kunin, MD, Madison
6. NEUROLOGY: The Effects of Headache on History—Arnold P. Friedman, MD, New York City
7. SURGERY: Wisconsin Committee on Trauma, American College of Surgeons

Name of Leader *Name of Leader*

First Choice: _____ Second Choice: _____

WEDNESDAY, MAY 12

LIST *TWO CHOICES* IN ORDER OF PREFERENCE

1. ANESTHESIOLOGY: Anesthesia Specialty Board Requirements: Questions & Answers—James H. Matthews, MD, Minneapolis
2. OPHTHALMOLOGY: No speaker. Business meeting to follow luncheon
3. ORTHOPEDICS: Mortality and Morbidity Associated with Treatment of Hip Fractures—Herbert E. Pedersen, MD, Detroit
4. OTOLARYNGOLOGY: Conservation Surgery Capsuled—Joseph H. Ogura, MD, St. Louis
5. SURGERY: The Future of Surgical Training and Care—Anthony R. Curreri, MD, Madison
6. SURGERY: Bronchitis–Emphysema Syndrome

Name of Leader *Name of Leader*

First Choice: _____ Second Choice: _____

Number Luncheon Tickets ($4.00 each) . . . _____ for $ _____

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Address .....
City ..... State ..... Zip .....
Arrival Date ..... Time .....
Departure Date ..... Time .....

Last Call for Entries in the

1971 ANNUAL PHOTOGRAPHY CONTEST

A SPECIAL FEATURE OF THE STATE MEDICAL SOCIETY'S ANNUAL MEETING PROGRAM

Entry form and contest rules appeared in previous issues of WMJ. Entries must be in at State Medical Society Headquarters in Madison by April 26, 1971.

The Summing Up

PRESIDENT'S PAGE

IT SEEMS INCREDIBLE that it is only eleven months since I addressed the House of Delegates in May of 1970 in which I had outlined my position as representative of the State Medical Society of Wisconsin. Throughout the year, we have had serious discussions with members of the Council, Executive Committee, and the Staff of the Society regarding our position in reference to Health Manpower in Wisconsin in the 1970's and 1971, and the proposed legislation in the Congress the coming year.

Initially we advocated that action be taken in the following matters:

1. Increased enrollment in the University of Wisconsin Medical School and the Medical College of Wisconsin in the near future.
2. Recognition of physician assistants with proper safeguards for the welfare of our patients.
3. That the State should increase the funds available to the two medical schools on the basis of actual enrollment.
4. Increase the number and quality of residency programs in Wisconsin hospitals, realizing that a doctor frequently takes up his initial practice in a state where he has received his postgraduate training.
5. To create a Student Liaison Committee to give advice and help to students who heretofore had very little contact with practicing physicians.
6. Provide long-term loans to medical students from the State with a "forgiveness" clause for those who practice in ghettos or remote rural areas.
7. Equalize the tuition fees at the two medical schools and make a greater effort to attract Wisconsin residents to practice in our State.

All of these ideas were detailed in a position paper of the State Medical Society put out last November under the title "Health Manpower in Wisconsin in the 1970's." This document has been widely distributed and I think fairly represents the hopes and aspirations of this Society.

We note with considerable satisfaction that many of these proposals are being recommended for legislative approval by a special committee of the Wisconsin Legislative Council. We hope for their adoption by the Legislature as a whole.

I am proud of the Society's approach in its manpower position paper in that we are on the positive side of many controversial issues. It is my belief that this "new image" should be continued in the future.

This manpower effort is the primary achievement of this present administration, in my opinion, and I wish to thank the Staff, the Chairman of the Council, Council members, and all those who are affiliated within an official capacity for carrying out the goals which we advocated in May 1970.

One totally negative aspect to health in Wisconsin is a cause for major distress. It is the continued and increasingly aggressive effort of chiropractors to obtain legislative approval for payment of their services under the Workmen's Compensation Act. Medicine cannot, in good conscience, accede to the expansion of what is a gross violation of sound public health policy. I know you will continue to express your opposition to this very dangerous legislation.

As I relinquish the office of President of the State Medical Society of 1971, I wish to thank Mr. Earl Thayer, Mr. Charles Crownhart, and all the Staff of the State Medical Society of Wisconsin, and all those who served so well in the Council or on presidential or other committees of the State Medical Society. I promise to give my undivided support to your incoming President, Dr. George Behnke, and assist in any way I can to fulfill the high aspirations of the State Medical Society of Wisconsin.

J. W. McROBERTS, MD

Fiscal Note: The Council and its Finance Committee are to be congratulated on keeping the Society "in the black" during 1970. The addition of about $27,000 to general reserves is a welcoming sign, and it is hoped that this trend can continue despite rising costs which affect our Society's operations as well as those in our own offices.

the WISCONSIN MEDICAL JOURNAL
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APRIL 1971
Vol. 70 No. 4

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Decade of Frustration

ABOUT TEN YEARS AGO the Kenosha County Medical Society and the Kenosha County Board worked out an arrangement that could have served as a model for efficient, sensitive and economic delivery of medical care to patients in county institutions. Regrettably, the results of the experiment were lost with the imposition of Medicare and Medicaid programs in 1966. As of January 1, 1971, the Kenosha contract, though successful, was terminated. Herein lies a lesson that could be useful to social planners: that locally devised programs for the delivery of medical service can work better, and at lower cost, than those imposed from on high.

This is the story. In 1960, the Kenosha County Board found itself in difficulty with two institutions it operates. One of them, Brookside, is a home for the aged with an average of 215 patients. The adjacent unit, named Willowbrook, is a tuberculosis sanatorium with a capacity of 44 patients, but with an outpatient service that went from 600 visits in 1955 to over 2,500 in 1961.

During a large part of the history of these two institutions, the medical service was furnished on a part-time basis and by means of temporary arrangements dictated by the needs of the patients. In 1957 a physician was engaged by the County Board, through its three-man Board of Trustees, to act as medical director for the two institutions on a full time basis; he divided his time between Brookside and Willowbrook and operated the outpatient clinic at the latter institution. Although his training and chief interest were in the field of tuberculosis, he made general rounds at both institutions about three times a week, and he freely utilized the services of various private physicians in Kenosha to handle medical problems arising at Brookside.

Brookside's population consisted largely of welfare recipients over the age of 60. A great number of them had chronic diseases that required frequent medical attention as well as complete nursing service. The care furnished these patients went well beyond that available in the average nursing home and often fell just short of full hospital service. In fact, the full time staff of Brookside included six registered nurses, eight licensed practical nurses, 46 nurses' aides and three male attendants.

After three years, personality clashes, differences regarding policy, and friction between the medical director, the trustees, the staff and others led to the resignation of the medical director. The Kenosha County Board found itself with two demoralized institutions, a lot of sick and elderly people and no medical direction.

At this point the County Board contacted the Kenosha County Medical Society for assistance in resolving its problem, and specifically to obtain medical coverage after the departure of the resigned medical director. After assuring the Board that adequate medical care would be provided and that there would be no deterioration in the service

provided any of the patients of either institution, the Medical Society studied the situation and came up with a plan.

It proposed to the Trustees an arrangement whereby the full-time salaried medical director would be eliminated. The entire membership would undertake to provide complete medical care to all Brookside and Willowbrook patients. The County Board would pay for this service with a predetermined monthly payment to the Medical Society, and the Society in turn would compensate each physician for the services he rendered. The Society would also provide a "Medical Director" to each institution.

The arrangement, patterned after the Western Foundations for medical care pioneered in San Joaquin, California, offered two important advantages. It enabled the County Board to know for a full year in advance exactly how much the medical services for the two institutions would cost. Each patient was enabled to use the services of his own family physician in accordance with his own need and escape the indignity of accepting the ministrations of a "charity" doctor. The quality of patient care would be improved by the assurance of a continuity of medical care; the development of medical staffs at both institutions was assured; political interference associated with governmental medical programs was eliminated. In short, all of the best features of private practice would be provided to all patients of the county institutions because the entire Medical Society was involved.

The Kenosha County Medical Society instituted its program on June 21, 1960, under the name of "Kenosha Physicians Service." One hundred percent of the active practicing doctors of the Society signed an agreement under which they agreed to accept a pro-rata reduction of their fees for services rendered to Brookside or Willowbrook patients in the event that the payment by the County was insufficient to cover the total of all statements for medical services. The agreement also provided that if the payment of the County to the Society exceeded the total charges of the participating physicians, the surplus could be transferred by the Society to one or more charitable, educational or scientific foundations or causes.

The plan proved an immediate success. Each patient at Brookside, the extended care facility, had his own personal physician and coverage five deep. If his doctor was unavailable, the designated alternate was called. Next the physician on rotating emergency call duty maintained by the Kenosha County Medical Society might be called, and finally the medical director or his assistant. At Willowbrook a TB specialist conducted outpatient clinics and made regular visits to the in-patients, directing their treatment. In addition, each patient had the services of his own doctor for medical problems of a non-tuberculosis nature.

Originally, the pre-payment fee established for Kenosha Physicians Service was $2,100 per month, about the same amount that had been budgeted by the County previously for physician services. In the first year, however, the Society twice reduced the pre-payment fee because the monthly payments appeared to be consistently more than was required to provide all the medical care necessary—which, incidentally, had substantially increased. And no doctor was compelled to reduce his usual and customary fee for services rendered. Although the quality and the quantity of care was steadily elevated, Kenosha Physicians Service was able to add money to reserves, and on several occasions made cash refunds to the County—even after some of the money was used for charitable purposes and for educational programs of indirect benefit to the patients of the two institutions.

This was the happy situation in 1966 when Medicare and Medicaid appeared. From then on, all billing except for patients on general relief, had to be made to the fiscal agent for these two programs. As a result, local bills for services rendered locally could not be reviewed and paid by a local review group, and utilization could not be as closely observed when billing correlation was lost. The money came from a larger pot, and the cost of providing the same, or similar service, has undoubtedly increased sharply.

The Kenosha Physicians Service gradually became superfluous, and as of January 1, 1971, it was discontinued. There simply wasn't enough billing to warrant renewal of the contract with the County Board.

What the Kenosha County Board had going for it should never have been interfered with. It was working extremely well at modest cost, and with complete satisfaction to the governmental agency involved, the patients and to the medical profession. Federal programs, despite their egalitarian obligations, should be flexible enough to preserve successful mechanisms that have already been established. Even now the federal government is promoting "Foundations for Medical Care," "experimenting" with some of the ideas that made the Kenosha scheme work ten years ago. It may yet be that the social planners in Washington will consult with health care people on the local level for what must, in the last analysis, be an intimate interpersonal relationship in the most localized sense.

—DNG □

STATE MEDICAL SOCIETY OF WISCONSIN ANNUAL MEETING
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WISCONSIN MEDICAL JOURNAL
Vol. 70, No. 4 APRIL 1971

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Society Council Favors AMA Medicredit Plan

The continuing improvement of the health of the American people is a many-faceted task, the State Medical Society of Wisconsin conceded this month when it issued a *Statement Concerning National Health Insurance Plans.*

Financing personal health services is but one element, the report stated. At least equal in importance are progress in assuring needed health manpower, improved health education, adequate income, and greater impact on the environmental factors affecting health.

Not surprising in a political atmosphere is the fact that public attention is being focused on several proposals involving the financing of personal health services, the Statement continued.

The State Medical Society believes that support should be given those proposals which best assure that:

One. A pluralistic system continues to develop which takes maximum advantage of the efficiencies of private health insurance mechanisms, motivates physicians to do their professional best, and assures the patient of satisfying, quality care.

Two. Everyone have protection against the financially catastrophic illness.

Three. Reduces centralized government control and bureaucratic regulation to a minimum.

Four. The people will be served in a manner that will be economically sound.

At this point in the 92nd Session of Congress, these elements appear most embodied in the AMA's Medicredit proposal, the Society's Statement pointed out. The key point is the preservation of a basically sound system of private health insurance and medical service. At the same time, it appears to offer reasonable fiscal control and quality assurance.

The Statement concluded with the following recommendation:

"The Council of the State Medical Society encourages every member of the Society to keep informed of the expanding developments in health care planning and legislation, and to exert every personal influence to bring about soundly conceived changes in the present systems."

On the following two pages of this GREEN SHEET appear the major points of the five national health insurance proposals prepared for the Council at its meeting March 27–28 at Society Headquarters in Madison.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

Senator John Tunney PACE Breakfast Speaker

A United States Senator from California will address physicians attending the PACE breakfast during the Annual Meeting of the State Medical Society, May 9–12, in Milwaukee.

John Tunney

John V. Tunney, son of former world heavyweight boxing champion Gene Tunney, will speak Tuesday morning, May 11, at 7:30 in the Imperial Ballroom (seventh floor) of the Pfister Hotel and Tower.

The 36-year-old lawyer serves on the Senate's Judiciary Committee, as well as the Public Works and District of Columbia Committees.

Tickets for the breakfast are $5 per person and may be ordered in advance by sending a check to: PACE (Professional Association for Civic Education), PO Box 68, Waterloo, Wis. 53594.

SMS Annual Meeting Programs Mailed

The Annual Meeting Programs were mailed in mid-April to all members who are urged to bring them along to the Meeting.

This issue's GREEN SHEET "Hot Line" summarizes the major issues to come before the House of Delegates.

NATIONAL HEALTH

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	AMA "MEDICREDIT"	SENATOR KENNEDY
FORMAL TITLE	Health Insurance Assistance Act	Health Security Act
RELATED SOURCES	H. R. 4960, H. R. 4961, H. R. 4962, H. R. 4963 and S. 987	S. 3 and Griffiths H. R. 22
SPONSORS AND SUPPORTERS	Over 120 members of the House of Representatives and several Senators	Committee for National Health Insurance; endorsed by AFL–CIO, UAW and Public Health Association
TIMETABLE	No timetable set; assumption is benefits would start first fiscal year after passage	Contributions starting 1/73; benefits starting 7/73
WHAT BENEFITS WOULD BE PROVIDED	Medicare would remain as is for aged; Medicredit would replace Medicaid for those under 65; private insurance policies would have to provide 60 days of in-patient hospital service in a 60 day period and a full range of out-patient and physician services in hospital, home, office; benefits would be subject to deductibles and co-insurance; catastrophic protection would pay expenses in excess of basic coverage reduced by percent of taxable income	Comprehensive benefits for most health services, including physicians, optometrists (and eyeglasses), podiatrists, dental for children up to 15 (later for all), unlimited hospital care, 120 days ECF care per spell of illness, prescribed appliances, home health care, lab services and x-ray, mental health care, prescribed drugs; there would be no co-insurance or deductibles, 120 skilled nursing days can be extended if home is owned by a hospital or payment is made through hospital's budget
WHO WOULD BE ELIGIBLE FOR BENEFITS	Total population would be eligible, with aged remaining under Medicare; participation would be voluntary	Compulsory for total population
HOW WOULD THE PROGRAM BE FINANCED	Income tax credits for purchase of private health insurance; tax credit graduated from 100% (income tax liability of $400) to 10% (liability over $1,300); poor receive health insurance certificates in lieu of cash; certificates would be financed through general treasury funds; patient would pay (a) $50 per stay in the hospital, (b) 20% of first $500 of expenses for out-patient or emergency care (maximum of $100) in a 12 month period and (c) 20% of the first $500 of expenses for medical care services (maximum of $100) in a 12 month period	3.5% tax on total employer payroll; 1% tax on employee wages up to $15,000; 1% on unearned income up to $15,000 and matching appropriation from general revenues equal to the total of above taxes (that is, 50% of total cost would come from general revenues)
WHAT WOULD THE TOTAL COST BE	Cost estimated at 14.5 billion for the first year. This figure would be reduced by cost savings from Medicare and reduced income tax deductions for medical care	Estimates range from $40 billion to $77 billion per year. Actual new federal money estimated to be $46 billion because much would be a reallocation of private and public funds now being spent on health care
HOW WOULD IT BE ADMINISTERED	Medicaid would be absorbed; Medicare would continue with intermediaries; private insurers would handle own participants under 65; Federal Health Insurance Advisory Board would establish standards for use by states in approving insurance plans	A five-member Health Security Board would report to HEW Secretary; regional, sub-regional and local Health Security offices to determine priorities, provider payments, facilities; Health Security Advisory Council of consumers. Encourages development of Foundations to become providers
WHAT ROLE FOR PRIVATE HEALTH INSURERS	No change in current role of private insurers; provider reimbursement methods would remain the same. Coverage would be purchased from carriers qualified by the state within federal standards	Would effectively eliminate all private health insurers; however, a non-profit prepayment or insurance organization which offers services to a specified population and meets the Board's other requirements, other than sponsorship by a medical society, could qualify
ACCESS	No proposed changes in the delivery of care; basically a financing mechanism to provide everyone the means to purchase basic health benefits	States that access to, and provision of, high quality health care is a right of citizenship; proposes redistribution of providers
MEDICAL PRACTICE	Doesn't challenge distribution of current resources; peer review by county medical societies would be mandatory	Funds allocated first to those in group practice and similar programs; residual to those on fee-for-service or per-case basis; would redistribute doctors where needed; special funds to train manpower
COST CONTROLS	Urges stronger utilization review; state insurance departments would approve premium rates	Strong fiscal incentive for group practice; fee schedule for fee-for-service practice; utilization review in hospitals and ECF's
QUALITY OF CARE	Peer review committees of local medical societies would be expected to maintain quality	Standards for participating providers, including surgery and other specialists' services; continued medical education required
CURRENT STATUS	Has been introduced in both the Senate and the House	Introduced by Senator Kennedy and 24 other Senators on 1–25–71 and by Representative Griffiths on 1–22–71

NSURANCE PROPOSALS

PRIL 1971

PRESIDENT NIXON	REPRESENTATIVE BURLESON	AMERIPLAN
National Health Insurance Standards Act (for employers) Family Health Insurance Plan (for poor)	National Health Care Act	Perloff Report to the American Hospital Association
President Nixon	Representative Burleson, 12 other Congressmen, Daniel Pettengil of Aetna, Health Insurance Association of America (commercial carriers)	Earl Perloff, Dr. Edwin Crosby
Employers required to start program by 7/1/73 which would also be starting date for the public portion	As early as 7/72; everyone by 1973	Not yet introduced in Congress; no timetable set as yet
Hospital and physician services in and out of hospital (including ECF's and home care); full maternity care; baby care including immunizations; vision care for children; out-patient laboratory services etc.; minimum catastrophic benefits of $50,000 per person per year	Physician services (office, home, health facility), laboratory charges, dental services, prescription drugs, contraceptives, prosthetic devices, physical and speech therapy; eye examinations, in-patient and out-patient hospital and ECF care, home health services, maternity costs; catastrophic illness costs. NOTE: Most of these subject to deductibles and co-payment	Health maintenance and catastrophic illness benefits package; standard benefits package for primary, specialty, restorative and health-related custodial care with emphasis on ambulatory services; physicians' services and acute hospital care; supplemental benefits packages to cover gaps between standard package and catastrophic illness and accidents
Public phase would provide free insurance to families of four with incomes of less than $3,000 per year; graduated schedule of charges for those earning up to $5,000. Private phase (financed by employers and employees) would cover all workers except state and local government employees, self-employed, domestics, part-time and seasonal workers	Voluntary for total population; except states must enroll the poor in state plans	Poor and near-poor would be provided coverage without charge; everyone else who bought the basic standard benefits would then get a government program of health maintenance and catastrophic coverages without cost, and could buy supplemental benefits if he chose
For public phase, social security earnings base would be raised initially to $9,800 per year; Medicaid would be replaced (except for aged, blind and disabled) with government paying up to $800 per year for premiums of Medicaid recipients. For private phase employer would pay not less than 65% of premium cost for first 2½ years (no more than 35% from employee) and 75% thereafter (25% from employee)	Partially through social security funds; largely through individuals paying premiums to administering carriers of Qualified State Health Care Plans equal to 18% of their incomes in excess of $2,000, $3,000 or $4,000, depending on size of family; premiums for indigent paid with state and federal funds into state pools; payments by near-poor scaled to income; individuals would deduct premiums from income tax; employers could deduct up to 100% of their premium payments from taxes	Would replace Medicare and Medicaid; health maintenance and catastrophic illness benefits for poor and near-poor by federal funds and for aged and all others by social security tax; standard benefits provided in same way except those financially able would purchase package; supplemental benefits available from prepayment plans and private insurance
Up to $8 billion per year in federal funds, plus undetermined employer–employee costs. Actual new federal money estimated to be $3.2 billion. $22 billion to be paid by private insurance	HHAA estimates $3.2 billion in additional taxes for first year (total cost $24 billion)	Estimated to be not less than the $70 billion now being spent
Health maintenance organizations to stress preventive care; employers would purchase a "standard benefit plan" with deductibles and co-insurance from private insurers; private insurance pools for risk-sharing among small employers, self-employed and people outside labor force; Medicare Parts A and B would be combined with no charge for Part B; Medicaid would apply only to aged, blind, and disabled	Council of Health Policy Advisors to counsel President and coordinate all federal health programs; state and areawide comprehensive health planning agencies to be involved; each state to set up Qualified State Health Care Plan; private carriers would provide benefits; Medicaid would eventually be replaced; Medicare would be retained	Through an innovation called a Health Care Corporation which all citizens would be encouraged to join; would bring together health care management, personnel and facilities in given geographical area into corporate structure to provide all levels of care; each state to legislate regulations; National Health Commission would replace HEW Department
Employers would purchase "standard benefit plan" from private insurers; a new federal agency would replace state insurance departments to regulate private insurance industry (on rates and standards such as requiring an option to join group practice plans, providing out-patient benefits, etc.)	Private carriers and prepaid group practice plans would provide benefits; insurers would underwrite each Qualified State Health Care Plan	Would let health insurers operate almost as they do now; they would sell standard benefits (to the financially able) and supplemental benefits packages
Health maintenance organizations would restructure delivery	Ambulatory care centers to make care available to all; policy council to advise on delivery of care	Would make total health care available to all through joining the Health Care Corporations
HMO's would encourage group practice plans; $545 million for medical scholarships and area health education centers; incentives provided to place physicians where needed	Increase manpower supply with student loans, federal grants; expand group practice; distribute manpower on basis of need	Every physician would have opportunity to participate in managing Health Care Corporations; incentives would favor ambulatory benefits and preventive care
Act would include cost controls; all but very poor would pay for part of care; preventive care designed to cut treatment costs; consumers would shop for least expensive plan	Ambulatory health care centers to reduce use of hospitals; planning agencies to aid in developing economic use of facilities, etc.; peer review of treatment and fees; state commissions to approve costs	Health Care Corporations would review use of services and allocate money; State Bureaus of Health Financing would set insurers' rates and determine need for federal funds
Employers would be required to purchase "standard benefit package"; act would include provider standards	Peer review of quality of care; Council of Health Policy Advisors to set quality guidelines	Health Care Corporations would provide peer review and other mechanisms to evaluate quality of care
Outlined in President's State of the Union address; fully developed in special health care message to Congress 2/18/71	Introduced in House December 10, 1970; went to Ways and Means Committee; reintroduced February 17, 1971	Adopted by AHA's House of Delegates January 27, 1971; no legislative sponsorship yet

SMS Hot Line

The following resolutions were received by the April 9 deadline and will go to the House of Delegates for action at the sessions beginning May 9 in Milwaukee. Members are urged to express their opinions to their delegates and, if they wish, to participate in the Reference Committee sessions where resolutions are discussed in detail. The Reference Committees will meet in open session at 7:30 p.m. Sunday, May 9. (The county medical society that has introduced the resolution appears in parentheses below.)

A. (Racine): Study the feasibility of a medical board of review for evaluating professional liability claims, and the possibility of a "group" liability carrier for all members of the Society.

B. (Fond du Lac): Asks that Wisconsin support the AMA's system of coding and nomenclature and that both WPS–Blue Shield and Surgical Care–Blue Shield adopt the system.

C. (Waukesha): Requests study of a professional liability insurance program for Society members.

D. (Richland): Asks that AMA reaffirm "that the best medicine is provided by the physician practicing under free enterprise."

E. (Richland): Requests that the AMA membership be polled regarding any unit values which may be attached to AMA-approved coding mechanism.

F. (Richland): Requests that the Legislature be petitioned to allow treatment of VD in a minor without parental consent.

G. (Richland): Encourages continued operation of three-year nursing schools.

H. (La Crosse): Requests that the State Medical Society choose its delegates to the AMA by direct election by the membership.

I. (La Crosse): Proposes a requirement that any contemplated AMA dues increase be communicated to each county medical society three months prior to the AMA House of Delegates meeting and that the vote of the county societies in each state be binding upon the delegates from each state.

J. (Clark): Asks for modification of state laws to facilitate the recruitment and employment of qualified out-of-state nurses.

K. (Dane): Asks that members of the medical profession use all proper means to resist the enforcement of payments which do not recognize the concept of usual, customary and reasonable payment established by the Medicare law.

L. (Dane): Urges that the medical profession object to HEW regulations which can create over-utilization of services in some instances and deny adequate patient care in others.

M. (Sheboygan): Asks for a state law requiring the installation and use of passenger restraint systems on all school busses.

N. (Milwaukee): Asks the Society and the Legislature to accept the wording of a Kansas statute as the official definition of death.

O. (Milwaukee): Commends the Society's position paper on health manpower and urges legislative adoption of its recommendations.

P. (Milwaukee): Requests amendment of Society By-laws to permit county societies to establish the amount of dues for hospital residents.

Q. (Milwaukee): Seeks the establishment of group protection for professional liability insurance in Wisconsin.

R. (Milwaukee): Commends Charles H. Crownhart.

S. (Milwaukee): Seeks the appointment of physicians to hospital governing boards.

T. (Milwaukee): Opposes the concept of national licensure of physicians.

U. (Milwaukee): Requests that no patient, physician, nurse or allied health professional be required by law or other mandatory directive to submit to, participate in or assist in the performance of an abortion for whatever reason.

V. (Milwaukee): Requests Society officers and staff to provide the Council and Finance Committee with continuing and comprehensive reports on all fiscal operations and that the Council be instructed to select the official outside auditors on an annual basis.

W. (Milwaukee): Commends the Society and Dr. R. E. Callan, Milwaukee, and members of the Medical Education Advisory Committee for the development of guidelines for the certification of Physician Assistants.

X. (Milwaukee): Opposes "Certificate of Need" legislation in Wisconsin.

Y. (Milwaukee): Asks for Society endorsement of legislation to establish minimum standards for ambulance attendants and equipment.

Z. (Door–Kewaunee): Requests reevaluations of the prophylaxis of ophthalmia neonatorum.

AA. (Waukesha): Requests insurance plans to provide coverage for treatment of alcoholics in general hospitals and encourages general hospitals to develop such treatment programs.

BB. (Waukesha): Requests establishment by the Society of a medical–legal committee to evaluate alleged malpractice and assist plaintiffs in obtaining expert medical testimony where justified.

CC. (Waukesha): Requests the Society encourage the formation of Regional Medical Liaison organizations geographically consistent with Comprehensive Health Planning organizations.

DD. (Waukesha): Asks the Society to design and promote a simple physical examination form and set physical and immunization standards for admission to all Wisconsin colleges and universities.

EE. (Waupaca): Opposes dictatorial HEW regulations as to fees and medical services.

trends

The Wisconsin Regional Medical Program, Inc.

APRIL, 1971

WRMP HIT WITH $92,000 CUT IN BUDGET; ALL RMP's TOLD TO REDUCE PROGRAMS 8½%

Budget Reduction Expected To Extend Thru '71-'72

The Wisconsin Regional Medical Program (WRMP) was notified recently to cut its budget for the remaining portion of this fiscal year by $92,000. The notification also indicated a possible reduction of anticipated funds totalling $130,000 for projects requiring support during the 1971-72 fiscal year which starts in September.

The 8½ percent budget cut came at approximately the same time that WRMP was hoping for an additional $200,000 in developmental funds which would allow full project funding at the local level.

Dr. John S. Hirschboeck, WRMP Coordinator, said the cutback has hit every Regional Medical Program in the country.

"It's going to hit us pretty hard also," he said. "It took a while to get over the shock especially when you're planning in anticipation of new funds. Our committees are going to have a great deal of work ahead of them. The Board of Directors has already made some decisions that have been pending."

At its last meeting the Board voted not to take additional office space in the Wisconsin Hospital Association office building under construction in Madison. It also voted to reduce the size of the present office facility to reduce rental by eliminating the conference room.

"Every step will have to be taken to assure success of our continuing projects," Dr. Hirschboeck said. "The Board has taken the initial steps in cutting back wherever possible in the internal operations of WRMP. It's going to be up to the committees and the Regional Advisory Group to examine each and every project and make further recommendations."

WRMP is in the process of making application for funds for the 1971-72 fiscal period to cover both project costs and WRMP operational costs. Funds will also be sought in an effort to begin new projects.

Application will also be made for another Developmental Award.

Dr. Hirschboeck noted that the application must be filed by May 1 and that notice of the award should be received about August 15. He stressed, however, that the Regional Advisory Group should be ready to meet serious priority problems of rebudgeting because of the expected cutback.

CHP Annual Meeting Set

Dr. Vernon E. Wilson, Administrator, Health Services and Mental Health Administration, will be the main speaker at the Annual Meeting of Comprehensive Health Planning Agency for Southeastern Wisconsin.

The dinner meeting will be held Thursday, May 20, Ramada Sands, 11800 W. Bluemound Rd., Milwaukee. Reservations can be made by calling the CHP office at 271-9788.

President's Message Suggests Expansion Of RMP Activities

In a recent budget message presented by President Nixon, it was pointed out that a major shift of emphasis for Regional Medical Programs is likely.

The President's message supports recent suggestions by Dr. Harold Margulies, newly appointed Director of Regional Medical Programs Service, that RMP's concern themselves more broadly with the overall quality of health care.

The President's message emphasized expansion of Regional Medical Programs to include programs to:

- Improve and expand service by existing physicians, nurses and other allied health personnel
- Increase utilization of new types of allied health personnel
- Provide new and specific mechanisms for quality control, improved standards and decreased costs in hospitals
- Provide means for early detection of disease
- Implement the most efficient use of all phases of health care technology
- Act as a catalyst to help initiate necessary consolidation or reorganization of health care activities to achieve maximum efficiency.

Regional Advisory Group Defines WRMP Role

The Regional Advisory Group adopted several new provisions and amendments to its bylaws to meet its expanding role in overseeing the activities of WRMP.

The Regional Advisory Group authorized:

- Increased membership to assure a broader representation of various health professions, organizations and agencies and members of the public,
- Allowing a maximum term of six years instead of three years to provide for rotation of membership with sufficient continuity for carrying out WRMP activities.

Amendments were adopted to:

- Increase the size of the Executive Committee from seven to nine members,
- Authorize the Executive Committee to approve applications for use of developmental award funds.

The following goals, purpose, objectives and policies were also approved:

Goals — The goals of WRMP are those of society embodied in the current WRMP legislation.

Purpose — The promotion of the health of the people in the region within the intent of WRMP legislation.

Objectives — To develop, demonstrate and evaluate the impact of new, existing or potential approaches for the delivery of health care.

Policies — 1) The intent of WRMP programs shall be funded projects and activities supported for limited periods of time to demonstrate their value and hasten their implementation in the health care service system. 2) The focus of these programs shall be through health care providers and health institutions and facilities. 3) The dimensions of the promotion of health shall include effective disease prevention, early detection and diagnosis, therapy, rehabilitation, and the maintenance of health. 4) The primary methods of implementation shall be making knowledge available, improving skills, providing technical support and marshalling interdisciplinary and community health resources. 5) The intended results of the application of these methods of implementation shall be a significant and measurable improvement in the health of people and/or the health care process. 6) WRMP should, at least on a biennial basis, review and evaluate its goals, purposes and objectives.

The Advisory Group also stated that WRMP must serve as a catalyst to bring about the development of programs through local initiative.

"It was recognized that every effort should be made to avoid unnecessary duplication of resources which are frequently inadequate, particularly in health manpower, and to establish programs which do not augment one program to the detriment of another. It believes that WRMP should support operational programs through contracts or agreements with other institutions or agencies rather than conducting operational programs itself. By working collaboratively with a broad spectrum of the health groups in the region, WRMP seeks to develop a network of communication and functional activity among medical centers, hospitals and health agencies in the region."

Cancer Program For Nurses June 14-25

A 10-day Cancer Program for registered nurses will be held June 14-25 at Marquette University, College of Nursing.

Sr. Ruth Gauthier, Cancer Chemotherapy Project staff assistant and associate professor, Marquette University, College of Nursing, said the course will be offered on a first come first served basis. Registrations will close May 1. Interested parties are asked to contact Sr. Gauthier at the College, 3029 N. 49th St., Milwaukee, Wisconsin, 53210. There is no fee for the course.

Medical Centers Show Progress

With approval of the final ph of the master plan, expected short the Medical Center for Southea ern Wisconsin will begin leasi sites for construction of facilit on the grounds of the Milwaul County Institutions.

According to D. C. Jacob President of the Medical Cen Council, membership to the Cen is available to those facilities g graphically located at the Cen as well as those physically loca in other parts of southeastern W consin with an interest in taki part in the medical center p gram.

The master plan of the Univ sity of Wisconsin Medical Cen to be constructed in Madison v approved by the Board of Rege last summer. Construction is pected to begin next year w space allocated to University H pitals, School of Medicine and School of Nursing.

Upon completion, both facilit anticipate a 50 percent increase graduating physicians to help m the health manpower shortage pr ently existing in Wisconsin.

Dr. Margulies Named RMPS Director

Dr. Vernon E. Wilson, Admir trator, Health Services and Men Health Administration, announc recently that Dr. Harold Margul has been confirmed as Direct Regional Medical Programs Serv

Radio Series Extended

"Focus On Your Health", series of radio programs modera by Dr. John S. Hirschboe WRMP Coordinator, and sp sored by Milwaukee radio stat WEMP, will be extended to clude approximately 19 new minute programs on health. T will bring the total number programs in the series to m than 30.

The programs can be heard ev Saturday evening, at 7:30 p.m.

The Regional Medical Program —Past, Present, and Future

By JOHN S. HIRSCHBOECK, M.D.
Coordinator, Wisconsin Regional Medical Program, Milwaukee.

EDITOR'S NOTE — This editorial is taken with permission from the Medical Tribune, March 3, 1971. Accompanying the editorial was a picture story regarding WRMP activities.

I EXTENDING the Regional Medical Program for another three years, the 91st Congress expressed satisfaction with the progress made by many of the 55 Re-nal Medical Programs now in existence throughout the United States and its ust Territories. The Congress preserved the categorical emphasis on heart, can-, and stroke and specifically added ney disease to the law. Diabetes and onic respiratory diseases are specific-y included as major related diseases earlier Congressional earmarking of propriations. It is obvious, therefore, t Congress intends to emphasize im-vement of the care of patients with onic diseases. In 1969, at the time of reorganization of the Department of alth, Education, and Welfare, the S. Public Health Service's Chronic sease Program was merged with the vision of Regional Medical Programs become the Regional Medical Pro-ms Service. Thus, this agency is now principal Federal organization in-lved in chronic disease control. At the ne time, the Department of Health, lucation, and Welfare looks upon gional Medical Programs as innova-s of change in the health-care system d as rapid disseminators of scientific owledge to providers of health care. The Regional Medical Programs have phasized continuing education for the alth professions. Training in new tech-logies, such as intensive coronary care rsing, has been conducted in most of the gram. The use of telephone, radio, and tomated audiovisual equipment has ex-nded rapidly. Interprofessional collabo-ion to improve educational program-ng and the strengthening of ties between dical centers and the communities have o been successfully introduced.

All Regional Medical Programs are nsored by one or more medical schools. dical societies and voluntary health ncies have joined with the universities lan and conduct projects. Pilot projects l demonstrations which are designed to eriment with new ways of providing lth care—particularly for those who l access to the health-care system difficult—have been attempted widely. Although it is impossible to quantitatively evaluate the impact of Regional Medical Programs on mortality and morbidity in the chronic diseases, it is apparent that the programs have been unusually effective as catalysts in bringing about collaboration and linkages between and among medical schools, hospitals, the health professions, and voluntary health agencies—and in a way heretofore not seen in our nation. The groundwork has been laid for a more efficient and rational way to deal with such complex problems as organ transplantation, high-voltage radiation therapy, stroke rehabilitation, and the management of coronary artery disease.

By its extension of the law, the Congress also emphasized the interrelationship of Regional Medical Programs with Comprehensive Health Planning. In many ways the individual Regional Medical Programs and the Comprehensive Health Planning Areawide Agencies have a reciprocal relationship. The former are concerned principally with action programs, whereas Comprehensive Health Planning is concerned principally with the planning and development of operational resources and the analysis of consumer needs and demands, including the social judgments regarding them. A Regional Medical Program, on the other hand, can readily become an agent for change in the health-care system because it has access to and an influence upon the professional and institutional components of the delivery system. Regional Medical Programs have a provider orientation, whereas Comprehensive Health Planning Agencies, according to law, are under consumer control.

Comprehensive Health Planning and Regional Medical Programs were both enacted by the 89th Congress. Each was sponsored by a different coalition of health interests. Comprehensive Health Planning in many ways became the legal implementation of a plan sponsored for many years by the American Public Health Association and schools of public health. Regional Medical Programs, on the other hand, arose out of the Report of the President's Commission on Heart, Cancer, and Stroke with the strong backing of voluntary health agencies, the American Medical Association, and the medical schools. It appeared at first that the two agencies might get in each other's way, and in some states difficulties actually occurred. As both programs mature, however, their complementary and supplementary nature becomes more and more evident, and it is likely that many functional interrelationships will develop between them. It is questionable, however, whether the programs should or will merge, or one become subservient to the other. Comprehensive Health Planning Agencies have strong ties to state and local governments and, as such, may be subject to political influences, whereas Regional Medical Programs are strongly tied to the universities and the health professions and function either as university agents or nonprofit corporations controlled by a coalition of the health professions and the universities.

THE NEXT THREE YEARS will be critical for both Comprehensive Health Planning and Regional Medical Programs. Their ability to work together with many often disparate interests to resolve the complicated problems in the delivery of health care will be carefully evaluated by the Department of Health, Education, and Welfare and by the public.

Congress, representing the public, has given great autonomy and flexibility through Regional Medical Programs Service to those who are responsible for delivering health care. If they succeed in effectively using these new instruments for interprofessional and interinstitutional planning and collaboration, there is less danger of a total reorganization of the health-care system under direct Government control.

Members Named To WRMP Committee

New members were named to the Revue and Evaluation Committee recently.

Named to the Committee were:

Harold C. Guntner, Chairman
Executive Director
Hospital Council of Greater Milwaukee Area
Milwaukee

William L. Blockstein, Ph.D.
Chairman, Health Sciences Unit
University of Wisconsin Extension
Madison

Kenneth D. Clark
Staff Representative
Wisconsin State AFL-CIO
Milwaukee

Glenn Hoberg, D.O.
River Falls

Dorothy J. Hutchison, R.N.
University Extension
University of Wisconsin-Green Bay
Manitowoc County Campus
Manitowoc

John R. Petersen, M.D.
Director of Medical Services
Milwaukee County Institutions and Departments
Milwaukee

George G. Rowe, M.D.
University Hospitals
Madison

Philip T. White, M.D.
Associate Dean, School of Allied Health and Continuing Education
Medical College of Wisconsin
Milwaukee

The objectives of the Committee are to:

1. Recommend to the Regional Advisory Group action to be taken regarding:
   a. Approval or disapproval of applications for WRMP funding, including changes in the budget. Decisions will be based on the quality of the proposals. Consultants may be called in and questions referred to appropriate study groups when necessary.
   b. Discontinuation of projects or portions of projects prior to scheduled termination.
   c. Establishment of evaluation procedures which are to be carried out by the Evaluations Director, with the help of the WRMP Staff and the Project Staff.
2. Prepare periodic and terminal reports regarding the progress of WRMP projects and programs for the Regional Advisory Group.

Trends is published quarterly by The Wisconsin Regional Medical Program, Inc., 110 E. Wisconsin Ave., Milwaukee, Wis. 53202. Articles for publication can be sent to the above address in care of Director, Public Information.

Board of Directors:

T. A. Duckworth, senior vice president and secretary, Employers Insurance of Wausau, Wausau, WRMP, President.

Donald C. Slichter, former president of the Northwestern Mutual Life Ins. Co., Milwaukee, Vice President.

Jerry W. McRoberts, M.D., president, State Medical Society of Wisconsin, Madison.

Orval H. Guenther, former director, Milwaukee County Institutions and Departments, Milwaukee. (Retired)

Eugene W. Arnett, administrator, Memorial Hospital of Taylor County, Inc., Medford.

Arthur C. Moeller, vice president for academic affairs, Marquette University, Milwaukee.

Wallace L. Lemon, vice president for planning and facilities, University of Wisconsin, Madison.

Peter L. Eichman, M.D., dean, University of Wisconsin Medical School, Madison.

Gerald A. Kerrigan, M.D., dean, Marquette School of Medicine, Inc., Milwaukee.

WRMP Program Coordinator:
John S. Hirschboeck, M.D.

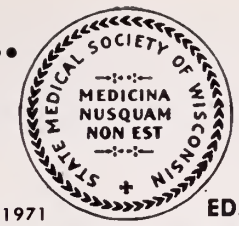
WRMP Director, Public Information and Communications
Peter A. Kirsch

WRMP Highlighted In Medical Tribune

Reprints of the center picture spread and editorial by Dr. Hirschboeck - The Regional Medical Program, Past, Present and Future - are available by writing:

Director, Public Information
Wisconsin Regional Medical Program
110 E. Wisconsin Avenue
Milwaukee, Wisconsin 53202

SECTION



OPHTHALMOLOGY

APRIL 1971

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

LOW VISION CLINIC REPORT

A total of 192 patients were served by the Low Vision Clinic of the Curative Workshop of Milwaukee in 1970. Sixty percent of these people were over the age of 65 years. Only seven percent were under the age of 21 years. Seventy-eight of the approximately 200 ophthalmologists in the State utilized this facility during the past calendar year.

Magnifying lenses and telescopic devices might make the difference between nearly total dependence on family members and independence. Many visually handicapped patients who are technically legally blind have been enabled to read recipes, thread needles, read their own mail and see traffic lights and bus numbers.

Albert E. Sloane, MD of the Massachusetts Eye and Ear Infirmary spoke to the Milwaukee Ophthalmic Society in February. He encouraged ophthalmologists to give their patients the opportunity to try using optical aids and indicated that all patients had a right to obtain maximal use of their residual vision.

Are there patients you have seen who have not been given the opportunity to use their vision to their greatest benefit?

LOW VISION CLINIC, Curative Workshop of Milwaukee, 750 North 18th Street, Milwaukee, Wisconsin 53233.

PHILIP TAUGHER, MD, Clinic Director and Clinic Ophthalmologist. MRS. MADALYN BRAUN, Program Coordinator.

OPTICIANS' BILL

Hearings were held March 25 in the Legislature on the opticians' licensing bill—S, 259. This bill would create a dispensing opticians examining council appointed by the Medical Examining Board in the Department of Regulation and Licensing. The council would consist of three members appointed for five-year staggered terms. Under the supervision of the Medical Examining Board, the examining council would serve as the regulatory body for dispensing opticians in the state. It would give examinations relating to the granting of licenses to dispensing opticians and would register all trainees. Acts are listed that could result in revocation, suspension, or the refusal to renew any certificate or registration. Violations of the act would be punishable as misdemeanors under s. 448.21 of the Wisconsin Statutes.

OPHTHALMOLOGIST JOINS MARSHFIELD CLINIC

Thomas W. Stram, MD has joined MDs James A. Kunkel and George M. Sparks in the practice of ophthalmology at the Marshfield Clinic in Marshfield.

Born in Milwaukee, Doctor Stram attended elementary and high school there, then attended the University of Wisconsin–Milwaukee from 1957 through 1960.

He attended the University of Wisconsin Medical School in Madison, graduating in 1964. His internship was spent at St. Joseph's Hospital in Marshfield from 1964 through 1965.

Doctor Stram spent two years in the U. S. Army Medical Corps with tours of duty in Korea and Fitzsimons Army Hospital in Denver, Colo.

He spent three and one-half years in ophthalmology residency at Marquette University School of Medicine from July 1967 until December 1970. While at Marquette he assisted Dr. Henry Edelhauser in the establishment of the Corneal Cryo-Preservation Unit.

NEW OPHTHALMOLOGIST AT UW

On April 1, George Bresnick, MD joined the University of Wisconsin Department of Ophthalmology. Doctor Bresnick received his BA degree from Harvard College and his MD from New York University Medical School. He interned at Boston City Hospital and completed five years of ophthalmology residency at Washington University in St. Louis in 1969. One of these years was spent in experimental ophthalmic pathology with Professor Norman Ashton in London.

Doctor Bresnick has spent the past two years as Chief of the US Army Joint Laser Safety Team directing research on medical effects of lasers at the Frankford Arsenal in Philadelphia. Doctor Bresnick has joined the Ophthalmology Department's Retina Service as an Assistant Professor. Among his particular interests are diabetic retinopathy, fluorescein angiography, laser applications in ophthalmology and retinal detachment surgery. □

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NEWS HIGHLIGHTS

Wis. MDs, Allied Health Professionals to Meet May 20 for Arthritis Topic

The first annual meeting of the Allied Health Professions Section of the Wisconsin Arthritis Foundation will be held May 20 at the Holiday Inn No. 2 in Madison.

All Wisconsin physicians and health-related professionals are being invited to the one-day affair which will start at 8:30 a.m. and continue until 5 p.m. The meeting site is located at the junction of I-90 and Highways 12 & 18 on the southeast fringe of Madison.

Addie G. Thomas, director of social work at the Johns Hopkins Hospital, Baltimore, Md., will keynote the meeting. She will speak on "Collaboration of Allied Health Professionals in Patient Care" at the noon luncheon.

Miss Thomas is a past president of the allied health professions section of the national Arthritis Foundation.

The morning program includes a discussion of "Introduction to Arthritis: Commonly Seen Rheumatic Diseases" by Walter R. Sundstrom, MD,* assistant clinical professor of medicine, University of Wisconsin Center for Health Sciences, Madison.

During the morning session, Dr. Sundstrom will serve as team leader for a presentation by the staff of St. Mary's Hospital Medical Center, Madison, on "The Team Approach to the Care of Arthritis." Also participating will be: Mary Emmett, director, social service department; Gail Auerbach, RD, therapeutic dietitian; Sr. Mary Solonita, RN, OTR; Victoria Graziano, PT, chief of the physical therapy department.

Andrew McBeath, MD,* assistant professor of surgery, University of Wisconsin Center for Health Sciences, Madison, will discuss "New Trends in Surgery for the Arthritic" during the afternoon session.

The meeting will conclude with a discussion of "Returning the Arthritic to the Community: Effective Utilization of Rehabilitation Resources." Rodney Van Deventer, administrator, Madison district office, Wisconsin Division of Vocational Rehabilitation, will moderate the panel. Participants will be Raymond Wilcox, chief of homecraft service, Wisconsin Division of Vocational Rehabilitation; and Wayne Dishaw, assistant director, Madison Opportunity Center.

Registration closes May 12. Registration is $5. There is no registration fee for students. Luncheon reservations are $3.50 per person.

Registration for both the program and the luncheon should be sent to: Allied Health Professions Section, Wisconsin Arthritis Foundation, 225 E. Michigan St., Milwaukee, Wis. 53202.

Racine Clinic Joins AAMC

The Racine Medical Clinic in Racine was recently elected to membership in the American Association of Medical Clinics.

The multi-specialty group was founded in 1952 with the association of G. N. Gillett, MD* and R. J. Mayer, MD.* The group is presently composed of 13 physicians, representing the following specialties: general surgery, pediatrics, internal medicine, obstetrics–gynecology, and family medicine.

Madison VA Hospital to Expand

A $1.6 million expansion project for the Veterans Administration Hospital in Madison was announced in March by the VA administrator, Donald E. Johnson.

A major benefit of the project will be construction of new surgical facilities so that open heart, vascular, and transplant surgery can be performed, Mr. Johnson noted.

Wausau Ob-Gyn Depts. Merge

In March the two hospitals in Wausau combined their obstetrics departments into one unit at Wausau Hospital South.

PHYSICIAN BRIEFS

Donald B. Comin, MD*

. . . La Crosse, recently joined the Skemp–Grandview Clinic and St. Francis Hospital medical staff. He graduated from Western Reserve University School of Medicine in Cleveland, Ohio, and served his internship and residency at St. Luke's Hospital, Cleveland. Doctor Comin served in the U. S. Army Medical Corps and was chief of medicine for the 44th Surgical Hospital, Mobile Army in Korea.

Burton K. Smith, MD*

. . . Wausau Clinic, recently was enrolled as a diplomate in the American Board of Family Practice as a charter member. Doctor Smith has been practicing in Wausau since 1952.

Dean A. Emanuel, MD*

. . . Marshfield, recently was reelected president of the Marshfield Clinic Foundation for Medical Research and Education. Thomas F. Nikolai, MD* is vice-president.

D. N. Goldstein, MD*

. . . Kenosha, recently was named vice-chairman of an 11-member committee which has been charged with the responsibility of making an intensive study of Kenosha County's mental health needs and then submitting recommendations to the Kenosha County Board. The committee's findings could result in a recommendation to build a major mental health complex somewhere in the county, the Board has indicated.

William E. Hein, MD*

. . . formerly of the Monroe Clinic, recently was named an assistant clinical professor at the University of Wisconsin Medical School, Madison. Doctor Hein will work in the family medicine program supported by a special legislative appropriation.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Hanno H. Mayer, MD*

. . . Milwaukee, recently was elected chief of medical staff at Sacred Heart Rehabilitation Hospital. Doctor Mayer also will serve as chief of the Department of Medicine.

Waldo R. Varberg, MD*

. . . Neenah; William M. Hebble, MD,* Beloit; David G. Bryant, MD,* Madison; and Clifton E. Peterson, MD,* Kenosha, recently were inducted as fellows of the American Academy of Orthopaedic Surgeons at its annual meeting held in San Francisco.

Bernard C. Korbitz, MD*

. . . Monona, recently was the featured speaker at the Midwest Cancer Conference which was held in Wichita, Kan. Doctor Korbitz spoke on "The Future Management of Leukemia."

Stanley J. Graiewski, MD*

. . . Oshkosh, recently was named a fellow of the American College of Sports Medicine. Doctor Graiewski, who had been in private practice since 1949 in Oshkosh, joined the faculty at the Wisconsin State University–Oshkosh Health Center in 1970. Doctor Graiewski is chairman of the State Medical Society's Committee on Disaster Medical Care and also serves on the Commission on Health and Natural Resources.

Charles K. Kincaid, MD*

. . . Madison, director of the Department of Public Health for 23 years, plans to retire July 1. Doctor Kincaid, a graduate of Ohio State University Medical School, was director of the Eau Claire city–county health department before taking the position in 1948 as city health director in Madison.

Warren H. Williamson, MD*

. . . Racine, has been elected president of the Racine Chamber of Commerce. Doctor Williamson is chairman of the board and medical director of the A-Center at Lincoln Lutheran Home, a director of the health division of the Southeastern Wisconsin Regional Planning Commission, and president of Family Planning Inc., in Racine.

WPHA Issues Anti-rubella Campaign Report

As many Wisconsin communities this spring prepare for another round of mass immunizations against rubella, the Wisconsin Public Health Association has issued a report of the anti-rubella campaign started in 1969 to prevent an unexpected 1970–1973 Wisconsin rubella epidemic.

The campaign was started in September 1969 by the State Division of Health. In October of that year it became evident that there would not be enough limited federal funds available to purchase enough vaccine to head off the epidemic.

Aware of the urgency for immediate action, the WPHA brought together representatives from health organizations around the state to lead a campaign that resulted in the Wisconsin Legislature appropriating $25,000 from state funds to the State Division of Health to carry out the campaign.

By Dec. 31, 1970, fifty-seven counties had completed the program for ages 1–12 and 14 more counties will complete it by May 1971, the report stated.

Altogether 80% of the children in Wisconsin at greatest risk of getting rubella (188,840 out of 241,035 aged 5–7) and 30% of the remainder of the target group (179,976 out of 591,125 ages 1–4 and 8–12) received the vaccine in the Division of Health program by the end of 1970, according to the report.

However, this does not include many children who received rubella vaccine from their family physicians.

It will be 1973 before it can be known whether the epidemic has actually been prevented, but there is every reason to expect a marked decrease in rubella cases in Wisconsin, the report concluded.

Allergists Meeting in May

The Wisconsin Allergy Society will be host to the 12th Annual North Central Allergy Society Meeting, May 8 and 9, at the Pfister Hotel in Milwaukee. Abe J. Sosman, MD* of Milwaukee is president of the state group.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MARCH 1971

2 Madison General Hospital Surgical Staff
2 Madison Urological Society
2 Madison Anesthesiology Society
2 Dane County Medical Society Board of Trustees
2 Dane County Medical Society Public Relations Committee
3 Professional Nurse Registration Exams
3 Executive Committee, SMS Commission on Public Policy
4 Professional Nurse Registration Exams
4 SMS Committee on Medicine and Religion
10 Steering Committee, Wisconsin Regional Medical Program
11 Wisconsin Section, International College of Surgeons
11 SMS Conference on the Physician Assistant
11 SMS Division on Alcoholism and Addiction
11 Board of Directors, Wisconsin Association of Professions
11 Madison Academy of Internal Medicine
12 SMS Commission on Scientific Medicine
13 SMS Commission on Health & Natural Resources
17 Dane County Medical Society —AMA Leadership Seminar
17 MEDIHC Operating Committee
18 Nursing Committee, Wisconsin Regional Medical Program
20 SMS Commission on Medical Care Plans
24 Legislative Committee, Wisconsin Association of Professions
26 Finance Committee of SMS Council
27 Executive Committee of SMS Council
27 AMA Delegates
27 SMS Council
28 SMS Council
28 SMS Realty Corporation
28 Wisconsin Perinatal Association/Liaison Committee of SMS Division on Maternal and Child Welfare (Oshkosh)
29 Wisconsin Perinatal Association/Liaison Committee of SMS Division on Maternal and Child Welfare (Oshkosh)
30 Wisconsin Perinatal Association/Liaison Committee of SMS Division on Maternal and Child Welfare (Oshkosh)
31 SMS Commission on Safe Transportation

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Coronary Surgery Highlighted at Wis. Heart Meeting

"An Appraisal of Coronary Surgery 1971" will set the theme for the annual scientific sessions of the Wisconsin Heart Association May 24–26 in Milwaukee at the Milwaukee Expo and Red Carpet Inn.

Co-sponsored by the Council on Clinical Cardiology and the Council on Cardiovascular Surgery of the American Heart Association, the program is under the direction of H. David Friedberg, MD.*

The program is directed to those who have daily intimate contact with coronary disease. It is designed to present, discuss, and criticize modern diagnostic approaches, surgical techniques, and the results currently being obtained in several leading cardiac centers. Registrants will be able to meet experts active in the field and to discuss a problem case of their own.

Guest faculty include: Eugene Braunwald, MD, University of California, San Diego; Henry Buchwald, MD, University of Minnesota, Minneapolis; C. Richard Conti, MD, Johns Hopkins U, Baltimore; Donald B. Effler, MD, Cleveland Clinic, Ohio; Dean Emanuel, MD,* Marshfield Clinic, Wisconsin; Charles K. Friedberg, MD, Mount Sinai School of Medicine of City University of New York; Richard Gorlin, MD, Harvard Medical School, Boston; Suzanne B. Knoebel, MD, University of Indiana School of Medicine, Indianapolis;

Charles Marks, MD, Mount Sinai Hospital of Cleveland and Case–Western Reserve U, Cleveland, Ohio; William E. Mateicka, MD,* St. Luke's Hospital Milwaukee, Wisconsin; Ben F. Mitchel, Jr, MD, U of Texas, Dallas; James J. Morris, Jr, MD, Duke U, Durham, N.C.;

George Robinson, MD, Montefiore Hospital and Albert Einstein College of Medicine, Bronx, N.Y.; George G. Rowe, MD,* U of Wisconsin, Madison; William H. Sewell, MD, Guthrie Clinic, Sayre, Pa.; and Frank C. Spencer, MD, New York U, New York.

A number of distinguished faculty of the Medical College of Wisconsin will also be participating in the program.

Further information and registration: Miss Lynne Kellaway, WHA, 205 West Highland Ave., Milwaukee, Wis. 53233.

JAMA to Be Printed by Wisconsin Firm

A Wisconsin printing firm recently was awarded the contract for printing the *Journal of the American Medical Association* (JAMA).

W. A. Krueger Co. of Milwaukee, which also produces in its plants in Milwaukee and in Phoenix, Ariz., the western and midwestern editions of *Business Week, Arizona Highways* magazine, and more than 50 other magazines, was awarded the contract at an estimated gross revenue to Krueger of more than $25 million over the long-term duration of the contract.

Printing under the new agreement will start September 1.

In changing printers the JAMA will be printed by web offset in place of rotary letterpress which will enable the journal greater freedom in use of four-color process.

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James W. Manier, MD*

. . . Marshfield, was one of several prominent authorities whose views form the basis for a series of articles on the relative virtues of solo vs. group medical practice, published in the Feb. 15, 1971, issue of *Patient Care* magazine.

Werner E. Langheim, MD*

. . . Madison, recently joined the International Neurosurgical Society.

Edwin L. Hiatt, MD

. . . Minocqua, recently became associated with Lakeland Medical Associates in Woodruff. Doctor Hiatt was formerly with the group for six months before entering service in 1968. He is a nephew of William Hiatt, MD,* a member of Lakeland Medical Associates.

William W. Engstrom, MD*

. . . professor of medicine and department chairman at the Medical College of Wisconsin in Milwaukee, is author of a major article in the Dec. 14, 1970, issue of *Modern Medicine*. Appearing under the heading "One Man's Opinion," Dr. Engstrom's article is entitled "Hierarchal Regression in Internal Medicine," in which he reviews "some of the contraindications, excesses, and overbeliefs that exist in medicine today."

Frederick W. Reichardt, MD*

. . . Stevens Point, was recently elected a representative to the Southern Advisory Council by the Portage County Health Resource Committee. Representatives of this Council will soon be named to the North Central Area Health Planning Association.

Archie H. Tax, MD*

. . . Whitefish Bay, recently was elected chief of medical staff at Doctors Hospital, Milwaukee. He succeeds J. B. Wilets, MD,* Milwaukee.

Robert L. Chancey, MD*

. . . Beloit, recently was named president of the medical staff at Beloit Hospital. William A. Pruett, MD,* was named president-elect and D. B. Pili, MD,* was elected secretary–treasurer.

Dennis G. Biros, MD

. . . La Crosse, recently became associated with the Gundersen Clinic and La Crosse Lutheran Hospital in the Department of Psychiatry. Doctor Biros graduated from the University of Minnesota Medical School and served his internship at Anker Hospital in St. Paul. His residency was taken at the University of Minnesota after which he entered the U. S. Army serving at the Basset Army Hospital, Ft. Wainwright, Alaska. He was chief of the department of neuropsychiatry at the hospital.

Romeo Biboso, MD

. . . Oak Creek, joined the South Milwaukee Clinic. He served his internship and residency at St. Anne's in Chicago and also did a year of resident work at St. Anthony de Padua, Chicago. He is a graduate of St Thomas Medical School in Manila, Philippines.

Allan J. Ryan, MD*

. . . professor of physical education at the University of Wisconsin Medical Center, was a contributing editor of the recently published International Encyclopedia of Sport Sciences and Medicine. Published by the Macmillan Co. of New York, the encyclopedia was sponsored by the UW and the American College of Sports Medicine. It is the first such publication of its kind. It summarizes scientific literature and serves as the definitive work in the field of sports medicine. Begun in 1959, the project developed into a publication of 1,707 pages with more than 1,200 articles written by more than 500 specialists from 46 countries. Leonard A. Larson, MD, chairman of the UW men's physical education department, was its executive editor.

Carl Zenz, MD*

. . . medical director of Allis–Chalmers Mfg. Co. of Milwaukee, participated in a postgraduate seminar April 19 during the American Industrial Health Conference in Atlanta, Ga. The seminar topic was "Human Work Physiology and Bio-Mechanics—What It Is, Where It Is Going and the Physician's Role."

CONTRIBUTIONS—CES FOUNDATION
February 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for February 1971:

Nonrestricted

State Medical Society Members ---------- Voluntary contributions of 477 MDs

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State Medical Society Members ---------- Voluntary contributions of 7 MDs

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Student Loans

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continued on next page

CES FOUNDATION CONTRIBUTIONS *continued*

Scientific Teaching

State Medical Society Members _____ Voluntary contributions of 20 MDs

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Brown County Loan Fund

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Museum of Medical Progress

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Prairie City Bank, Design Homes Inc., GTC Motor Parts & Equipment, Meyer Brothers, Richard J. Kozelka, Skyway Motel _____ Ecology Exposition

ANNUAL SCIENTIFIC SESSIONS OF

THE WISCONSIN HEART ASSOCIATION

An Appraisal of Coronary Surgery 1971

May 24–26 • Milwaukee

Milwaukee Expo and Red Carpet Inn

Co-sponsored by: Council on Clinical Cardiology and Council on Cardiovascular Surgery, American Heart Association

Program Director: H. David Friedberg, MD

George M. Goza, Jr., MD

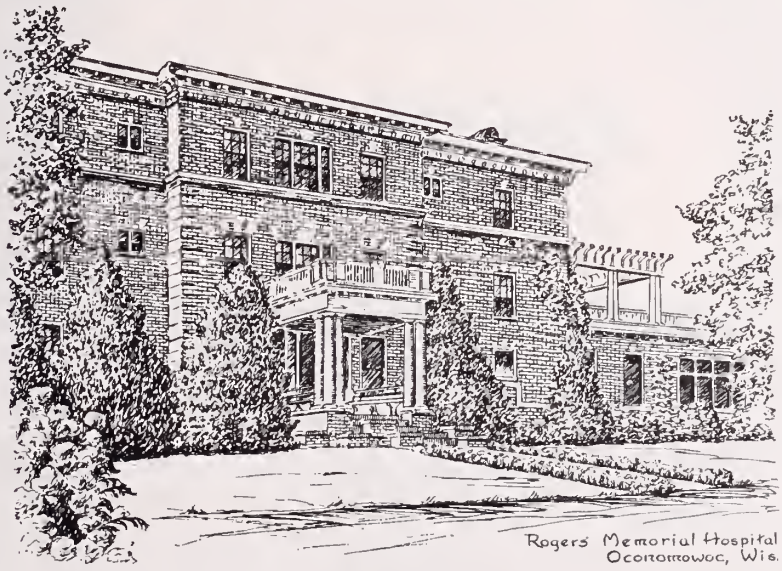
. . . Cumberland, recently was appointed the full-time psychiatrist–director of the Northern Pines Guidance Clinic, Cumberland. Doctor Goza was in private practice for six years in Atlanta, Ga.

E. C. Welsh, MD*

. . . of Milwaukee was inadvertently omitted from the section representatives on the State Medical Society's Commission on Public Policy listing in the January 1971 Blue Book issue of WMJ. He was appointed last year to represent the newly created Section on Physical Medicine and Rehabilitation.

J. V. Herzog, MD

. . . formerly of Milwaukee, has been elected president of the recently organized Sun City (Arizona) Physicians Club. According to the Club's secretary, Harry P. Lee, Sun City is a retirement city near Phoenix with a population of 17,000. Of its 95 resident physicians, 74 are fully retired. □



MEDICAL STAFF

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Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

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Perinatal Care Group Organizes

Physicians, nurses, pharmacists, and other members of the health-care team involved with maternal and child care, especially newborn care, met March 28–30 in Oshkosh to form a new organization known as the Wisconsin Association for Perinatal Care.

The association's purpose will be to evaluate and plan future maternal and child health-care services and programs for the benefit of all Wisconsin people, Stanley N. Graven, MD,* chairman of the planning committee stated.

Dr. Graven is Director of the Newborn Center, St. Mary's Hospital, Madison.

The State Medical Society's Division on Maternal and Child Welfare will be directly involved in the new group's endeavors.

Other members of the planning committee, which also met last November to discuss formation of the association, are:

Beverly Aure, RN, OB Unit, University Hospitals, Madison

Helen Callon, RN, Newborn Center, St. Mary's Hospital, Madison

Gertrude Howe, MD,* Director, Bureau of Community Health Services, State Division of Health

Weir Horswill, MD,* Madison General Hospital, Madison

Anita Grand, RN, Maternal and Child Health Nursing Consultant, State Division of Health

Mary Thomas, Head Nurse, Intensive Care Nursery, St. Vincent's Hospital, Green Bay

Kenneth Mickle, MD,* Green Bay

Joe Durst, MD,* La Crosse

Jacqueline Heal, OB Supervisor, St. Francis Hospital, La Crosse

Cliff Peterson, MD,* Fond du Lac

Jack Schneider, MD,* Department of Obstetrics, University of Wisconsin, Madison

Ruth Redmann, RN, School of Nursing, University of Wisconsin, Madison

Lois Jacobs, RN, Milwaukee County Hospital School of Nursing, Milwaukee

William Fetherston, MD,* Milwaukee

Eugene Krohn, MD,* Krohn Clinic, Black River Falls

Marilyn Burgess, RN, Instructor, School of Nursing, Wisconsin State University–Eau Claire, Eau Claire

Mary Lewis, RN, Newborn Nurseries, St. Joseph's Hospital, Milwaukee

Marion Owen, RN, State Division of Health, Madison

National Ambulatory Medical Care Survey Field Test Started

A National Ambulatory Medical Care Survey (NAMCS) is currently being planned by the National Center for Health Statistics in the Department of Health, Education, and Welfare.

The survey is expected to provide objective, quantitative information enumerating the types of ambulatory patients seen by physicians, the nature of the patients' problems, and the resources for their care.

A field test is underway now with a sampling of 750 physicians across the country. According to information from the American Medical Association which is supporting the survey, there are some Milwaukee physicians involved in the field test.

The AMA stressed that cooperation of the entire sample is essential for success.

When the survey is in full operation in 1972, it is estimated that some 3,000 physicians and 240,000 ambulatory patients will provide data each year. All physicians will be replaced by new sample physicians after participating for four quarters.

The largest segment of the American health services system in terms of volume and prevalence is ambulatory services. Information obtained from the survey is needed for planning and organizing health services, for planning efficient utilization of health facilities and manpower, and for determining modifications in medical education.

Watertown Hospital Moves

Watertown Memorial Hospital ended 65 years of service at the Concord and Main Street site in Watertown on March 1 when the hospital moved to its new 4 million dollar facility on Little Street and Highway 16 Bypass.

A "Master Plan" for the move enabled the smooth transfer in one day.

Dr. E. H. Jorris Honored at Retirement Affair

E. H. JORRIS, MD,* WHO RETIRED January 31 as state health officer after 34 years in state service, was honored by fellow employes at a luncheon early in February. Dr. Jorris received an engraved watch and a purse of money which he proudly displays while his successor, George H. Handy, MD,* looks on. Dr. Jorris headed the State Division of Health, formerly known as the State Board of Health, from May 1965 until his retirement. The Division has about 500 employes. Dr. Jorris entered state service in 1936 when he became a district health officer in Mauston and Sparta. In 1940 he came to Madison to head a new state tuberculosis program. He served three years in the Navy during World War II, then returned to Madison in 1946 to become assistant state health officer under the late Carl N. Neupert, MD. When Dr. Neupert retired, Dr. Jorris assumed his post. Born and reared in La Crosse, Dr. Jorris received his MD degree in 1929 from the University of Minnesota. He practiced medicine in Excelsior (Richland County) before joining the state health agency. (Photo courtesy State Division of Health) □

Precision is a natural goal when you prescribe thyroid replacement therapy.

When you prescribe Proloid (thyroglobulin) you specify a precision blend of the two natural active hormones—T_4 and T_3—in their natural protein, *thyroglobulin.*

It's because Proloid is the natural thyroid hormone-globulin complex extracted and purified of unnecessary glandular debris.

91 control tests, 2 clinical assays: Beginning with the USP iodine assay and continuing through chromatographic analysis for T_4 and T_3 content and including testing in hypothyroid humans—Proloid is made as precise as the natural product can get, batch after batch.

New 2 grain tablet: Precision extends to dosage. With the introduction of a new 2 grain tablet, titration can be even more conveniently achieved with the full range of Proloid dosages: *¼, ½, 1, 1½, the new 2, 3, and 5 grain tablets.*

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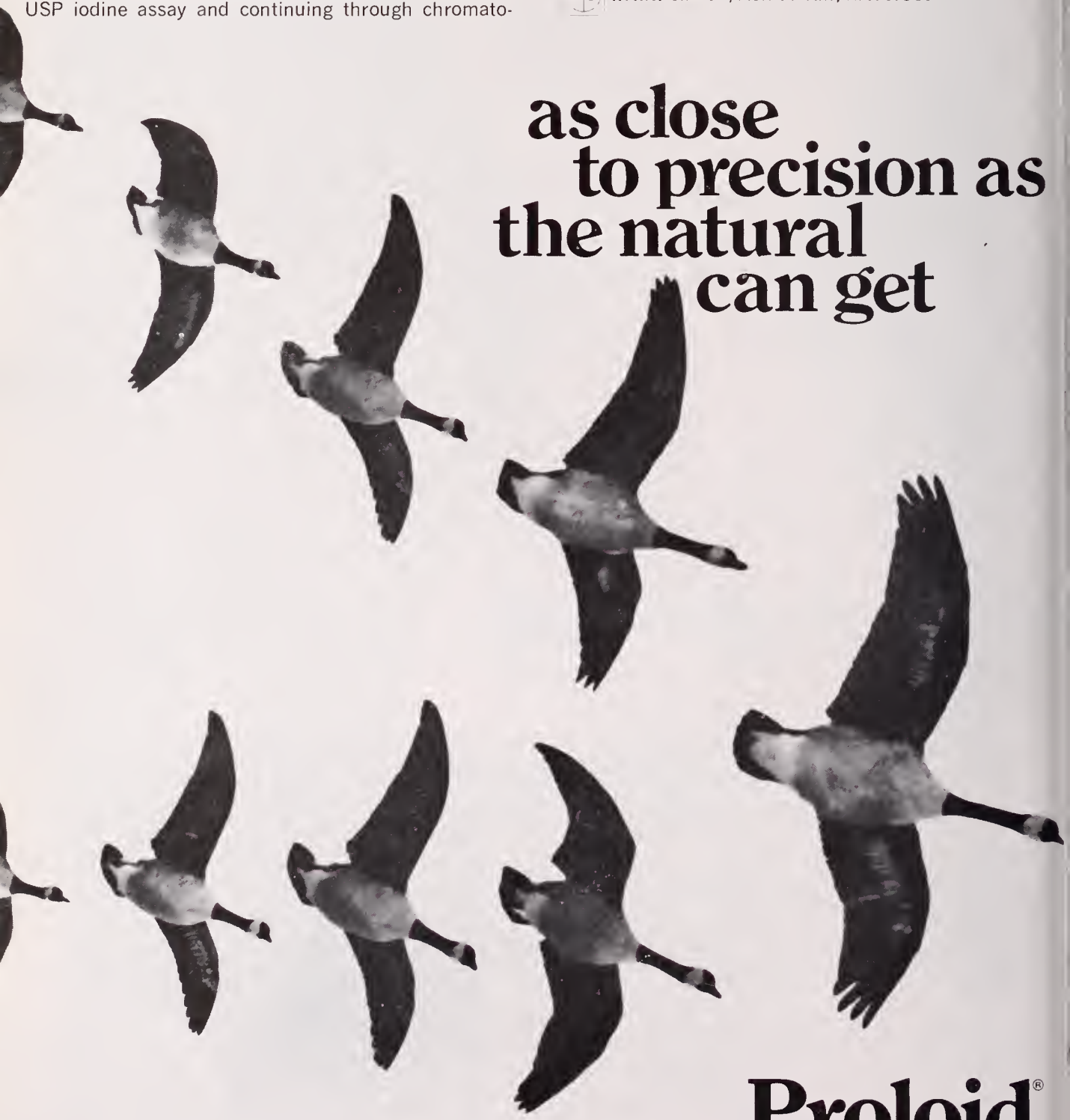

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(thyroglobulin)
the natural for precision

PR-GP-12-B&W

Proloid®(thyroglobulin)

Description: Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, sodium levothyroxine (T_4) and sodium liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the sodium levothyroxine and sodium liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications: Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication: Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings: Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid, and dosage should be started at a very low level and increased gradually.

Precaution: As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions: Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration: Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Instructions for Use: The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

Dose of Proloid (thyroglobulin)	Dose of desiccated thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

Overdosage Symptoms: Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied: ¼ grain; ½ grain; scored 1 grain; 1½ grain; 3 grain; and scored 5 grain tablets, in bottles of 100 & 1000; and scored 2 grain tablets in bottles of 100.

Warner-Chilcott, Morris Plains, N. J. 07950

OBITUARIES

Paul Kimmesteil, MD, 70, Milwaukee, died Oct. 7, 1970, in Oklahoma City, Okla.

Doctor Kimmesteil was born on March 21, 1900, in Hamburg, Germany, and attended the medical schools of Hamburg, Munich, and Tuebingen in Germany where he obtained his medical degree in 1923. His specialty was bacteriology and immunology. He was associated with Marquette University School of Medicine, Milwaukee, before joining the teaching staff at the University of Oklahoma.

He was a member of The Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Thomas E. Lynn, MD, 45, Green Bay, died Feb. 3, 1971, in Green Bay.

Born on Oct. 8, 1925, in Dubuque, Iowa, Doctor Lynn graduated from Northwestern University Medical School in 1950 and interned at Mary Hitchcock Memorial Hospital, Hanover, N. H. In 1950, he was a surgical resident at Passavant Memorial Hospital, Chicago. Doctor Lynn was a fellow in surgery at the Mayo Graduate School of Medicine, Rochester, Minn., and served in the United States Navy during the Korean War.

He received a degree of master of science in surgery from the University of Minnesota in 1956 and accepted a residency in thoracic surgery at the Veterans Administration Research Hospital in Chicago. He also was a resident in general surgery in the Evanston Hospital, Evanston, Ill., from 1957–58.

He entered private practice in Green Bay where he was a member of the staff of St. Vincent's, Bellin Memorial, and St. Mary's hospitals. He was a member of the Wisconsin Surgical Society, a fellow of the American College of Surgeons, and a member of the Central Surgical Association.

Doctor Lynn was a member of the Brown County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Joanne; two sons, Thomas Jr., and Robert; and four daughters, Diane, Mary, Julie and Kathy.

William P. Hamilton, MD, 59, Dodgeville physician and surgeon for 35 years, died Feb. 7, 1971, in Dodgeville.

Born on Oct. 19, 1911, in Ridgeway, Wis., Doctor Hamilton attended Campion Jesuit High School at Prairie du Chien, Wis., received his Bachelor of Science from Notre Dame University in 1932, and graduated from Marquette University School of Medicine in 1936. He served his internship at St. Joseph's Hospital in St. Paul, Minn. He was a veteran of World War II and served in the U. S. Navy from 1944–1946. He had a solo practice in Dodgeville until he became associated with N. G. Rasmussen, MD, at the Dodgeville Clinic in 1957 and they were joined by D. R. Downs, MD, in 1961. He was on the medical staffs of St. Joseph's Hospital and the Dodgeville General Hospital, Dodgeville, since 1936.

Doctor Hamilton was a fellow of the American Society of Abdominal Surgeons and a member of the American Academy of General Practice. He also was a member of the Iowa County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow, Margaret, the former Margaret Miller of Milwaukee, two sons, Capt. Thomas with the U. S. Marine Corps, Oceanside, Calif., and William, Whitewater; five daughters, Susan, Madison; Mrs. Richard (Judy) James, Dodgeville; Mrs. John (Jane) Crubaugh, Pulaski;

Mrs. Robert (Kathryn) Rundle, Menomonee Falls; Mrs. Perry (Ann) Schaack, Milwaukee.

Doctor Hamilton was posthumously awarded the Certificate of Merit of the American Academy of General Practice.

Charles Whitmarsh Crumpton, MD, 52, Madison, died Feb. 7, 1971, in Madison.

Born on Oct. 8, 1918, Doctor Crumpton graduated from Tulane University Medical School in 1942 and served his internship with University Hospitals, Madison. He served with the United States Army Medical Corps during World War II and was state surgeon with the Wisconsin Army National Guard. After service, he was a resident in internal medicine at University Hospitals, Madison, and from 1948–1950, he was a research fellow at the Robinette Foundation for Cardiovascular Research at the University of Pennsylvania where he remained as an instructor until 1951. He joined the University of Wisconsin Medical School as an assistant professor, becoming a full professor in 1962.

Doctor Crumpton, former president of the Wisconsin Heart Association, was a founding member of the Association of University Cardiologists. In 1968, he was governor for Wisconsin of the American College of Cardiology.

He was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Richard H. Juers, MD, 88, Wausau, died Feb. 16, 1971, in Wausau.

Born on April 29, 1882, in Clinton, Iowa, Doctor Juers graduated from the University of Illinois Medical School in 1914 and served his internship at West Suburban Hospital in Oak Park, Ill. He was a druggist before taking up medicine in 1914 and was associated with the Marshfield Clinic before locating in Wausau. He retired from practice in 1953.

He was a member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are two brothers, Charles and Emil, Ridgeway, Pa.

Earl S. Carey, MD, 80, Wisconsin Dells, died Feb. 16, 1971, in Portage.

Born on May 15, 1890, in Cleveland, Ohio, Doctor Carey graduated from Rush Medical College, Chicago, and served his internship at Chicago Memorial Hospital. He practiced in Chicago from 1924–1953 until he moved to Wisconsin Dells. He retired from active practice in 1967.

Surviving is his widow, Anna. □

TWO WYETH FILMS AVAILABLE

Happy Family Planning is an eight-minute animated, color film with music, available in either 16-mm. or 8-mm. The film, using graphic devices and no dialogue, reviews various contraceptive methods which are identified in five languages: English, French, Spanish, Arabic and Chinese. *Happy Family Planning* is designed for showing to lay groups, especially hospitalized women in the immediate postpartum period. It also can serve as a valuable educational aid in clinics, physicians' offices and at health meetings.

Case In Point outlines precautions by which the medical assistant and her physician–employer can help protect themselves from lawsuits. Using a documentary approach, *Case In Point* depicts various professional activities of the medical assistant, and dramatizes the importance of observing fundamental safeguards in each area. The film, which is 16-mm., color, and runs 25 minutes, is available for showing to physicians and to chapters of the American Association of Medical Assistants.

Prints of either film can be obtained on loan through Wyeth representatives or the Wyeth Film Library, P. O. Box 8299, Philadelphia, Pa. 19101.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF MARCH 15, 1971

NEW MEMBERS

Abdallah, Wadie A., 3533 East Ramsey Ave., Cudahy 53110
Bauman, Richard O., 425 East Wisconsin Ave., Milwaukee 53202
Bayley, Bruce, 733 West Clairemont Ave., Eau Claire 54701
Belgado, Paulino G., Jr., 10—10th St., Clintonville 54929
Bernards, Walter C., 8700 West Wisconsin Ave., Milwaukee 53226
Bertelson, James N., 114 West Olin Ave., Madison 53715
Buan, Rolando R., 302 East Franklin, Sparta 54656
Buck, Charles R., 215 North 91st St., Milwaukee 53226
Burgfechtel, Robert J., 2211 Stout Rd., Menomonie 54751
Castillo, Marcelo G., 1672 South 9th St., Milwaukee 53204
Cohill, Donald F., 2405 Northwestern Ave., Racine 53404
de Leon, Jose J., 501A Main St., Boyceville 54725
Fagan, Anne M., 2092 South 102nd St., Milwaukee 53227
Fink, Jordan N., 5537 North Navajo, Milwaukee 53217
Grieshop, Joseph L., 5757 West Oklahoma Ave., Milwaukee 53219
Hilton, David, 103—1st Ave., West, Menomonie 54751
Holmburg, Charles E., 9523 West Beckett Ave., Milwaukee 53225
Kampine, John P., VA Hospital, Wood 53193
Kennan, Alfred L., 1300 University Ave., Madison 53706
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Kiernan, John H., Jr., 3821 West Oklahoma Ave., Milwaukee 53215
Kim, Dia Kap, 3216 Meachem Rd., Racine 53405
Kim, Yong W., 14995 San Marcos Court, Brookfield 53005
King, Brian J., 5932 Tower Dr., Eau Claire 54701
Kingham, James D., 845 North 26th St., Milwaukee 53233
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Straumfjord, Jon V., Jr., 8700 West Wisconsin Ave., Milwaukee 53226

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Dvorak, Harold J., Drawer 11-0, Milwaukee 53201
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Gallen, William J., 4031 North Lake Dr., Milwaukee 53211
Gandy, Theodore I., 3924 North Ridgefield Circle, Milwaukee 53211
Gilmore, Richard L., 3316 Watergate Rd., Indianapolis, Ind. 46224
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Jurevics, Ingrid E., 38249 Lakeland Dr., Oconomowoc 53066
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Koziol, Raymond S., 1982 Prospect Ave., Milwaukee 53202
Kreissl, Leonard J., Jr., P. O. Box 1709, Santa Rosa, Calif. 95403
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Levenson, Ernest, P. O. Drawer 8D, Milwaukee 53201
Levenson, Ina, 3168 South 27th St., Milwaukee 53215
Lillie, Richard H., 811 East Wisconsin Ave., Milwaukee 53202
Lorton, William L., 929 North Astor St., Apt. 1607, Milwaukee 53202
Majewski, Joseph T., 6001 West Center St., Milwaukee 53210
Martens, Thomas J., 805 NW Elizabeth Way, Corvallis, Ore. 97330
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McAndrew, John B., 2136 White Swan Dr., Oshkosh 54901
McFadden, Wayne, 100—15th Ave., South Milwaukee 53172
McLaughlin, John T., 10202 Jon Day Dr., Huntington Beach, Calif. 92646
Murphy, Paul W., 1111—15th Ave., Bloomer 54724
Nepomuceno, Ruben A., 101 Shepherd Terrace St., Clairsville, Ohio 43950
Nickel, Frederick A., 211 South Monroe Ave., Green Bay 54301
Nickels, Robert J., 1004 East Sumner St., Hartford 53027
O'Connor, Robert D., 5733 North Kent Ave., Milwaukee 53217
O'Leary, Elmer B., 3425 South Princeton Ave., Milwaukee 53215
O'Loughlin, Peter D., 9191 Watertown Plank Rd., Milwaukee 53226
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DEATHS

Kimmelsteil, Paul, Milwaukee County, Oct. 7, 1970
Lynn, Thomas E., Brown County, Feb. 3, 1971
Crumpton, Charles W., Dane County, Feb. 7, 1971
Hamilton, William P., Iowa County, Feb. 7, 1971
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Juers, Richard W., Marathon County, Feb. 16, 1971 □

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Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel 608/262–6594.

BOOKS RECEIVED

THE FUNCTIONS OF THE POLICE IN MODERN SOCIETY

By Egon Bittner, PhD, Brandeis University. National Institute of Mental Health, 5454 Wisconsin Ave., Chevy Chase, Md. 20015. November 1970. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 122 pages. Price: 55¢

DRUG SEMINAR

By Winnebago State Hospital. 1970. 60 pages. Price: $1.00

DIAGNOSIS AND THERAPY OF THE GLAUCOMAS

By Allan E. Kolker, MD and John Hetherington, Jr., MD. The C. V. Mosby Co., St. Louis, Mo. 1970. 495 pages. Price: $25.00

SELECTIVE BIBLIOGRAPHY OF ORTHOPAEDIC SURGERY

By American Academy of Orthopaedic Surgery. The C. V. Mosby Co., St. Louis, Mo. 1970. 114 pages. Price: $7.25

BEHAVIORAL SCIENCES AND MENTAL HEALTH: An Anthology of Program Reports

National Institute of Mental Health, Chevy Chase, Md. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 1970. 419 pages. Price: $2.00

PUBLIC HEALTH STATISTICS WISCONSIN—1969

Published by Division of Health, Department of Health and Social Services, 1971. Bureau of Health Statistics, Section of Statistical Services, P. O. Box 309, Madison, Wis. 53701. 91 pages.

HANDBOOK OF PEDIATRICS—Ninth Edition

By Henry K. Silver, MD, C. Henry Kempe, MD, and Henry B. Bruyn, MD. Lange Medical Publications, Los Altos, California, 1971. 713 pages. Price: $6.50

MENTAL HEALTH RELATED ACTIVITIES OF COMPANIES AND UNIONS

Behavioral Publications, Inc., 2852 Broadway–Morningside Heights, New York, N. Y. 10025. 1971. 91 pages.

BOOK REVIEWS

MANUAL ON ARTIFICIAL ORGANS, Vol. I, The Artificial Kidney —A guide to understanding for the physician and patient

By Yuhihiko Nose, MD, PhD. The C. V. Mosby Company, Saint Louis, Mo. 1969. 343 pages. Price: $27.75

Doctor Nose has attempted to present in a concise and clear manner the technical aspects of hemodialysis. He has performed this task quite admirably by the use of concise descriptive material in conjunction with numerous drawings and diagrams.

The favorable aspects of this volume concern primarily the tables related to the specifications of various dialyzers

commercially available and the complete bibliography. The various technical aspects of initiating dialysis are quite clear, as are the description of the insertion of arteriovenous shunts and the construction of arteriovenous fistulae.

Criticisms of the volume basically relate to the fact that one of necessity acquires a somewhat one-sided opinion about a subject which, of course, has many viewpoints, particularly in regard to dialysis technique. The initial chapter regarding normal physiology is brief and I feel incomplete, although, of course, there are many references available on this subject.

To summarize, this volume will prove most useful as a reference standard in any dialysis unit, particularly in terms of information relating to various dialyzers and to the usefulness of the bibliography. This reviewer does not believe that it is too useful for the lay person, but can be used as a source for the development of training programs for home dialysis. Despite the rather high cost, every dialysis unit should probably have a copy.—WELDON D. SHELP, MD

TOWARD A BETTER BREED

By Karl E. Kassowitz, MD. Vantage Press, Inc., 120 W. 31 Street, New York, N. Y. 1970. 127 pages. Price: $3.75

Karl E. Kassowitz, MD, Milwaukee, has recently published a book in three parts entitled "Toward a Better Breed" and with the subtitle of "Reflections in Three Mirrors" (Vantage Press, New York). This trilogy consists of first, the story of a young man and his love for an older woman. Perhaps the author was influenced by Sigmund Freud, an old friend of the author's family, and this may represent an Oedipus complex.

The second portion of this tripartite presentation is autobiographical. Doctor Kassowitz was born in Vienna in 1886 and was the son of a famed Viennese pediatrician and his family friends were the medical greats of that era. Following graduation from the University of Vienna, Doctor Kassowitz served in the Austrian army medical corps. He was taken prisoner by the Russians and shipped to Siberia. He escaped through Manchuria and Peking to the United States, then to Gibraltar and finally rejoined the Austrian forces on the Italian front. This was described in a book entitled "Around a World on Fire" which Doctor Kassowitz published about forty years ago.

KASSOWITZ

After the war Doctor Kassowitz married a Swiss nurse and they migrated to the United States with their young son. Doctor Kassowitz is a multifaceted and remarkable man, with interests in music, mountain climbing and medical innovations as well as in writing. Examples of his medical daring were the use of intravenous Mercurochrome when his own wife was critically ill with puerpural septicemia and the use of his own cerebral spinal fluid to replace that in a youngster with tuberculous meningitis. The autobiography ends with a poignant epilogue describing his son who was lost in an Air Force crash at age 21.

Part three of the trilogy is an allegorical playlet in which Doctor Kassowitz expresses his optimistic hope for the future.—VICTOR S. FALK, MD

* * *

Dr. Kassowitz who has practiced medicine for more years than this reviewer has had birthdays, calls himself "a rebel against convention"; and some of his outlooks, which are brought to the surface in this trilogy, do in fact bear a remote resemblance to some outlooks of today's social rebels. The work, subtitled *Reflections in Three Mirrows*, is certainly unconventional. The tone is set in the author's preface where he indicates his awareness that man's destiny goes beyond daily metabolism and struggle for survival, and where he suggests that man's higher purpose as interpreted by Freud was the superego, and as interpreted by Christianity was the Kingdom of God.

Part One of the trilogy is a love story, rather hurriedly told, but with essentially spiritual overtones. An older woman and a younger man, heretics against social convention and disbelievers in Original Sin, but strong believers in spiritual honesty, touch on one of society's pressing problems—that of morality. The second part of the work is essentially a charming autobiography of a period long past where great changes occurred in medical practice; and where a practicing physician, for want of anything better to offer a seriously ill patient, looked to untried research techniques for help. I enjoyed this part of the work best. The last of the trilogy is a playlet which gives the work its title, and in which the author looks optimistically to the future. I find allegories difficult to ponder; but I hazard that this essentially religiously oriented book is an expression of the author's view on the all-encompassing nature of the Kingdom of God on earth.—J. M. BENFORADO, MD

CURRENT CONCEPTS IN OPHTHALMOLOGY

By Bernard Becker, MD, and Ronald M. Burde, MD. The C. V. Mosby Co., Saint Louis, Mo. 1969. 267 pages. Price: $21.00

At a time when there is an ever increasing "education gap" between new discoveries and concepts and their appearance in standard text books and reference works, volumes such as *Current Concepts in Ophthalmology: Volume II* edited by Drs. Becker and Burde are becoming increasingly popular and welcome.

With contributions from the present and former staff of the Oscar Johnson Institute at Washington University in St. Louis this not too lengthy, but well rounded little book is an excellent "short course" in post-graduate ophthalmology.

The chapters on herpes simplex keratitis, diagnostic techniques in the management of intermittent exodeviations, the treatment of amblyopia, and home orthoptics for the ophthalmologist should be of especial value to the general ophthalmologist.

The discussions of biomicroscopy of the fundus, fluorescine angiography and the chapter on dyslexia are most timely and contain considerable "new" information to help keep the ophthalmologist abreast of the latest techniques. Some of the chapters will be of interest to only a few, but there is a broader range of topics than in Volume I and in general the basis for publication of the book is sound. Definitely recommended reading.—FRANK L. MYERS, MD

ATLAS OF DIAGNOSTIC TECHNIQUES AND TREATMENT OF INTRAOCULAR FOREIGN BODIES

By William H. Havener and Sallie L. Gloeckner. The C. V. Mosby Company, Saint Louis, Mo. 1969. 197 pages. Price: $19.50

The easily interpreted illustrations are the outstanding educational feature of this book. The printed page is presented on the left hand side of the open book and the accompanying illustration is printed on the right hand side of the book. This makes for quick and easy reference to the illustrations as one reads along. The excellent accompanying illustrations make it possible to keep the printed text short. The text is short, to the point, and full of practical, helpful hints. The book can be quickly read and comprehended because of the numerous illustrations. Use of the indirect ophthalmoscope is emphasized.

This book will be of the greatest interest to ophthalmology residents. However, even the experienced ophthalmic surgeon will find many practical, helpful suggestions.—JAMES C. ALLEN, MD □

the wisconsin medical journal

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POSTGRADUATE COURSES

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1971 WISCONSIN

Aug. 5–28: Scandinavian/Russian Holiday, Wisconsin Alumni Association. Info: Wisconsin Alumni Tours, 650 N. Lake St., Madison, Wis. 53706.

Sept. 10–11: Annual scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel and Tower, Milwaukee.

Sept. 22: Sixth annual Adolf Gundersen Symposium for Physicians—"Understanding Arrhythmias." Co-sponsored by the Wisconsin Heart Association and the Adolf Gundersen Foundation. Valhalla Hall, Wisconsin State University, La Crosse.

Oct. 17–23: Wisconsin Work Week of Health.

1971 NEIGHBORING STATES

June 16: *Symposium on Genetic Counseling,* presented by Children's Memorial Hospital, Chicago; sponsored by The National Foundation–March of Dimes, at Sheraton Chicago Hotel, Chicago. Info: Chicago Chapter–National Foundation, 173 West Madison St., Chicago, Ill. 60602.

Summer: *1971 North Michigan Summer Course,* University of Michigan Department of Postgraduate Medicine, Traverse City at Shanty Creek Lodge, Bellaire. Info: U–M Dept of PG Med, Towsley Center for Continuing Medical Education, Ann Arbor, Mich. 48104.

Sept. 13.–15: *Clinical Electroencephalography.* American Electroencelphalographic Society, in Minneapolis, Minn. Info: Donald W. Klass, MD, EEG Course Dir., Mayo Clinic, Rochester, Minn. 55901.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Oct. 4–9: Postgraduate course in Laryngology and Broncho esophagology, Department of Otolaryngology of the University of Illinois at the Medical Center, University of Illinois Eye and Ear Infirmary, Chicago, Ill.

Oct. 10: Joint scientific meeting, American College of Preventive Medicine and Association of Teachers of Preventive Medicine, Hotel Leamington, Minneapolis, Minn.

Oct. 23–29: Annual Otolaryngologic Assembly of 1971, University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

1971 OTHERS

June 7–11: Annual convention, Catholic Hospital Association, Atlantic City, N.J.

June 7–11: *Internal Medicine: Clinical Problems, 1971.* American College of Physicians, University of Cincinnati Medical Center, Ohio. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

June 21–26: Annual General Practice Review, University of Colorado School of Medicine, Estes Park.

June 28–July 2: *Advances in Internal Medicine: Recent Perspectives.* American College of Physicians, University of Alberta Medical School at Edmonton, and the University of Calgary Medical School, to be presented at the Banff School of Fine Arts, Banff, Alberta, Canada. Info: Registrar, Exec. Dir., ACP, 4200 Pine Street, Philadelphia, Pa. 19104.

July 5–8: *Ophthalmology.* University of Colorado School of Medicine, Colorado Springs.

July 11–14: *Pediatrics.* University of Colorado School of Medicine, Aspen.

July 11–22: *Summer Program in Human Sexuality.* Lecture courses with special reference to the medical aspects of human sexuality, workshops in sex education and counseling, small group discussions. $325, includes housing. Registration ends May 30. Write: Summer Program, Institute for Sex Research, Indiana University, Bloomington, Ind. 47401.

July 20–24: *Internal Medicine.* University of Colorado School of Medicine, Estes Park.

July 22–23: Second annual *Seminar in General Surgery,* Colby College, Waterville, Maine. Info: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.

July 26–29: *Recent Advances in Rheumatic Diseases.* American College of Physicians and University of Colorado School of Medicine, Estes Park.

July 29–31: *Chronic Inflammatory Diseases of the Gut,* American Gastroenterological Association, Aspen, Colo. Info: Mrs. Bernie C. Kern, 740 Krameria St., Denver, Colo. 80220.

Sept. 27–Oct. 1: *Hospital Medical Staff Conference,* University of Colorado School of Medicine, Estes Park.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Oct. 5–7: *18th Spinal Cord Injury Conference.* Joint meeting of Veterans Administration Department of Medicine and Surgery and International Medical Society of Paraplegia, Children's Hospital Medical Center, Boston, Mass.

Nov. 9–10: Annual Scientific Meeting, Council on Arteriosclerosis of the American Heart Association, Anaheim, Calif.

Nov. 11–14: 44th Annual Scientific Sessions, American Heart Association, Convention Center, Anaheim, Calif.

Nov. 15–18: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, 307 No. Charter St., Madison, Wis. 53715)

Nov. 17–19: Annual Conference, National Society for the Prevention of Blindness, Inc., The Roosevelt Hotel, New York City. (Papers, panel discussion and seminars on the latest developments in detecting and combating potentially blinding eye disease, community-action eye health programs, and programs for industrial and school safety.)

1971 AMA

June 20–24: AMA Annual Session, Atlantic City, N.J.

Aug. 30–31: Congress on Occupational Health, Jackson Lake Lodge, Wyoming.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

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Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Apr. 23–29: Ninth Interamerican Congress of Cardiology, San Francisco, Calif.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Biltmore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New York N.Y. 10017.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

For listing of other meetings see the **Journal of the American Medical Association.**

General Practice Review—Colorado

The Summer Presentation of the seventeenth annual General Practice Review of the University of Colorado School of Medicine will be held June 21–26 at the YMCA Conference Center in Estes Park.

It is almost identical in course content and format to the Winter Sessions with one day devoted to each of six major fields of practice: (1) Medicine, (2) Pediatrics/ The Critically Ill Child, (3) Dermatology, (4) Surgery and Trauma, (5) Obstetrics and Gynecology, and (6) Psychiatry. This course is acceptable for 48 prescribed hours by the AAGP.

On the preceding day of the opening of the conference, there will be a one-day symposium on "The Family Physician's Role in the Management of Alcoholism," also at the YMCA Conference Center. It is being sponsored by the Colorado Academy of General Practice, the Alcoholism and Drug Dependence Division of the Colorado Department of Health, the Harmony Foundation, and the University of Colorado School of Medicine. This course is acceptable for 5 prescribed hours by the AAGP.

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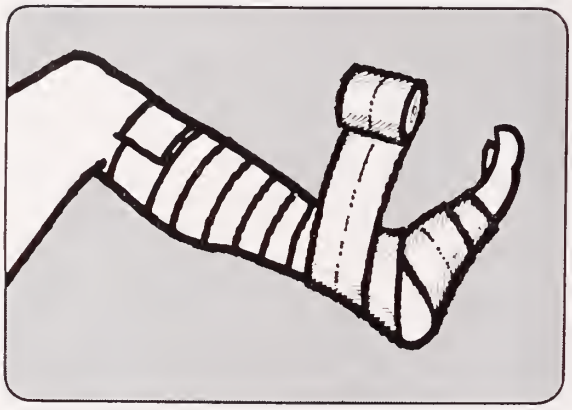

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Registration to the Summer Presentation should be made with The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220. Registration and tuition: $110. Registrants may indicate their desire to attend the preceding day's symposium.

Preventive Medicine Meeting in Minneapolis

The American College of Preventive Medicine and the Association of Teachers of Preventive Medicine will sponsor a joint scientific meeting in Minneapolis on Sunday, October 10, at Hotel Leamington. Highlight will be the 15th Annual ACPM Lectureship. H. Bruce Dull, MD, Assistant Director, Center for Disease Control, Atlanta, will speak on "The Law and Medicine: Allies or Adversaries?".

Further information may be obtained by writing: American College of Preventive Medicine, 801 Old Lancaster Road, Bryn Mawr, Pa. 19010; tel. 215/LA5-54560.

Laryngology and Bronchoesophagology

The Department of Otolaryngology of the University of Illinois at the Medical Center will conduct a postgraduate course in Laryngology and Bronchoesophagology from October 4 through 9.

This course is limited to 15 physicians and will be under the direction of Paul H. Holinger, MD. It will be held largely at the University of Illinois Hospital Eye and Ear Infirmary, 1855 West Taylor Street, Chicago, and will include visits to a number of other Chicago hospitals. Instruction will be provided by means of animal demonstrations and practice in bronchoscopy and esophagoscopy, diagnostic and surgical clinics, as well as didactic lectures and several motion pictures.

Interested registrants should write directly to the Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, P.O. Box 6998, Chicago, Ill. 60680.

Interamerican Cardiology Congress Sets Oct. 1 as Abstracts Deadline

Oct. 1, 1971, has been set as the deadline for receipt of abstracts of papers intended for presentation at the Ninth Interamerican Congress of Cardiology, being held in San Francisco, Calif., from April 23–29, 1972.

The meeting is sponsored by the Interamerican Society of Cardiology and is being hosted by the American Heart Association with the cooperation of the California and San Francisco Heart Associations.

Chief objectives of the Interamerican Congress are the presentation of new and important educational and research material and an interchange of ideas by cardiologists in the Western Hemisphere.

Included in the tentative program are plenary sessions on such subjects as hypertension, coronary artery disease, genetic and congenital heart disease, inflammatory heart disease, and cardiac failure. Simultaneous sessions will be devoted to a variety of topics through the presentation of approximately 100 original papers, panel discussions, and lectures.

Official forms to submit abstracts of papers and registration and hotel reservation forms may be obtained from the Department of Councils and International Program, American Heart Association, 44 East 23rd Street, New York, N.Y. 10010.

THE NEW PRESIDENT

George A. Behnke, MD

■ Dr. George A. Behnke of Kaukauna assumed the presidency of the State Medical Society of Wisconsin this month in Milwaukee during the Society's Annual Meeting. ■ During his 25 years as a general practitioner, Doctor Behnke has served his medical societies in a number of capacities. In 1958–59 he was president of the Outagamie County Medical Society. He was elected vice-speaker of the State Medical Society's House of Delegates in 1964 until 1967 when he became the speaker. He remained speaker until 1970 when he was elected president-elect. In this position he served as a member of the Executive Committee of the Council, the Commission on Public Policy, and the Commission on Medical Care Plans. He also participated in numerous committee meetings and Society functions throughout his term. ■ Doctor Behnke was born on Nov. 11, 1917, in Oshkosh. ■ He received his Bachelor of Science degree from the University of Wisconsin, then his medical degree in 1942. After internship at St. Luke's Hospital in Duluth, Minn., Doctor Behnke entered the United States Army as a First Lieutenant, serving until his discharge in 1946. ■ Doctor Behnke returned to the Fox River Valley where he settled in Kaukauna to establish a general practice in partnership with Dr. G. L. Boyd. Later he helped establish the Kaukauna Clinic. ■ Doctor Behnke is affiliated with the Kaukauna Community Hospital, of which he was chief of staff in 1955 and 1965. He also serves on the medical staffs of St. Elizabeth and Appleton Memorial hospitals. ■ In 1946 he joined the Outagamie County Medical Society, State Medical Society of Wisconsin, and American Medical Association. He also is a member of the Wisconsin/American Academy of General Practice. ■ Active in community affairs, Doctor Behnke served as president of the Junior Chamber of Commerce in 1949–50 and was president of the Rotary Club in 1958–59. He was vice-chairman of the Outagamie County Heart Unit of the Wisconsin Heart Association, a member of the Board of Education for 12 years and served as its president in 1965–66, and serves as the City Health Officer. ■ Doctor and Mrs. Behnke, the former Leigh Krahn, are parents of four children: Mary (wife of Dr. John) Place, Fort Riley, Kan.; Carol, a teacher in Special Education at Belvedere, Ill.; Susan (Mrs. Jack) Dempsey, Green Bay; and George K., a senior at Kaukauna High who expects to attend the University of Wisconsin–Madison with a major in mathematics. □

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EDITORIALS

D. N. GOLDSTEIN, M. D., *Editorial Director*

Ovid O. Meyer, MD

THE FESTSCHRIFT IN THIS ISSUE is indeed a fitting tribute to the greatness of Dr. Ovid O. Meyer. In a lifetime of dedication to medical science, research papers have been the medium of exchange for the ideas and knowledge that formed the basis of his teaching. He has achieved worldwide acclaim as an expert on lymph node disorders and his comments on Hodgkin's disease constitute a rare privilege for the editorial columns of the *Wisconsin Medical Journal.*

Distinguished member of an outstanding faculty, Doctor Meyer's influence on countless physicians has been profound. As professor of medicine of the University of Wisconsin Medical School, soon to become emeritus, he has transmitted not only the science of medicine but also those special qualities of humanity that make the difference between a mere medical scientist and a practitioner of the art of healing.

Doctor Meyer's devotion to the advancement of medical knowledge is demonstrated by the roster of national scientific societies of which he is a member: American College of Physicians, Central Society for Clinical Research, American Society for Clinical Investigation, American Board of Internal Medicine, Association of American Physicians, and others. But in the 45 years since he received his MD degree from Columbia University, Doctor Meyer has grown in more than scientific knowledge. The brilliance of his personality and the greatness of his character, molded by the nobility of his career and seasoned by the weight of the life vocation he has chosen for himself has made this man a giant among his colleagues.

The philosopher Irwin Edman once noted that the ultimate society of the mind is an isolated haven crowded with friends in the form of congenial themes. In the minds of medical students who attended the University of Wisconsin Medical School, one of the congenial themes that will recur again and again will be an idea communicated by Doctor Meyer—the compassion, the moderation, and the practical common sense of a fine teacher.

As we pay tribute to Doctor Meyer in this issue, we pay tribute to the golden age of the University of Wisconsin Medical School by applauding one of its golden men.—DNG

Hodgkin's Disease in the New Decade

After approximately forty years of experience in the management of patients with Hodgkin's disease and other malignant lymphomas, I have observed great changes in the specific therapy of these malignant disorders—especially so during the past decade. In the early years roentgen therapy—directed to the obvious sites of disease—was available and utilized. In the 1940s a potent chemical, mechlorethamine, (nitrogen mustard), became available to add to our armamentarium. Since then, several other aklylating agents have been utilized and more recently—the vinca aklaloid drugs, vinblastine and vincristine, and later still, procarbazine (Matulane®).

The report of Easson and Russell[1] in 1963, the more recent reports of Kaplan[2] and his associates, and Johnson et al[3] have offered convincing evidence that Hodgkin's disease in early stages is curable in 40 percent or more of the cases; i.e., there is survival for 10 years or more. The anticipated life span for those free of disease after 10 years is akin to that of the general population. Much larger doses of radiation (3500–4000 rads or more) are now given over wider areas from cobalt sources, million volt x-ray generated, or linear accelerator.

Easson and Russell[1] have stated "the urgent need is for radical therapy and curative intent, especially in those cases with localized disease." Almost identical cure rates were obtained for patients with lymphosarcoma and reticulosarcoma.[1] A patient with localized disease adequately treated with no relapse in 2 years has a distinctly improved prognosis, and one who remains well for 5 years has a very good chance of reaching 10 years and 15 years or more without recurrence.

The introduction of staging for Hodgkin's disease, and we use this to a certain extent for other lymphomas, adopted by the symposium held in Rye, New York in 1965,[4] has been vital in clarifying some of our thinking about the indicated type of treatment and the prognosis of Hodgkin's disease. In summary, Stage I refers to lymph node disease limited to one anatomic region, for example, one side of the neck. Stage II, disease in 2 or more areas on one side of the diaphragm, such as the neck and mediastinum. Stage III, disease on both sides of the diaphragm, but not extending beyond involvement of lymph nodes, spleen or Waldeyer's ring. Stage IV, is indicative of involvement of one or more tissues, bone marrow, lung, pleura, liver, bone, gastrointestinal tract, kidneys or any tissue or organ in addition to the lymph nodes, spleen, or Waldeyer's ring. These stages are divided into A, without systemic symptoms, and B, with systemic symptoms, defined for these purposes as fever, night sweats, pruritus, or weight loss greater than 10 percent. It is quite generally accepted now that the prognosis after adequate therapy is best for Stage I and II A, poorest for Stage IV. The implication is obvious, early diagnosis and accurate staging followed by prompt and thorough therapy is indicated—and some optimism is called for rather than the general pessimism that once prevailed when it was presumed that the average life span was about 2 or 3 years.

It has long been my belief that with the introduction of the potent chemicals a patient's economically sound and comfortable life could be extended, but it has never been established that life was actually prolonged. However, it now appears that much more can be done by using combined chemical therapy with drugs that act by different mechanisms in the cell to destroy the tumor, and in intermittent courses. Currently, we are using for patients in Stage IV simultaneous administration of vincristine, (Oncovin®), cyclophosphamide (Cytoxan®) procarbazine (Matulane®) and prednisone. This regimen or a similar regimen may also be most suitable for Stage III B. As of now, most therapists favor radiation for Stage III A and perhaps III B, but this is still unsettled and further data are necessary. Devita et al[5] had reported a definitely better response rate and probably survival in Stage IV using a combination of four drugs in a cyclical fashion for six months as compared to single drug therapy sequentially.

There are significant well recognized risks in using any extensive and intensive treatment, and detailed studies should antedate for staging and for optimal protection of the patient. These studies include complete history and physical examination, lymph node biopsy, urinalysis, possibly renal function studies, complete blood counts, bone marrow study, liver function tests, liver biopsy if necessary, chest x-ray film, tomograms of the mediastinum as indicated, and possibly surgical exploration of the abdomen with biopsy of suspected node disease and perhaps splenectomy. Any attempts at treatment should ordinarily be made only after these studies are completed, and I would emphasize that at this time, these patients should be managed in centers where experienced individuals in the fields of medicine, or pediatrics, hematology, oncology and radiotherapy are available. We are becoming quite certain that malignant lymphomas are not by any means necessarily fatal if the patient is given the optimal chance of cure. Early and correct decisions are of paramount importance that may decide the prognosis.

I must emphasize that we do not by any means know all of the answers. Better treatment and perhaps less toxic agents will evolve. However, there is still need for better controlled studies and more objective data—and the necessary information must be acquired if the patients of the future, cared for by the future generation of physicians, are to get a better opportunity for a normal life span. This will require that the physicians who first see these

patients direct them promptly to centers that care for many of these cases with a personnel that has a sincere avid interest in the problems they present. The primary management of malignant lymphomas is a difficult undertaking. It goes without saying that complete facilities for management, including adequate follow-up, must be available.

Although the situation in many of these centers is improving, looking to the future, there is still a need for greater objectivity and less enthusiasm for one or other forms of therapy. Critical assessment of the treatment results in comparable groups of patients is absolutely necessary or we will find ourselves in a situation 10 or 20 years from now that is little better than that of the present. As of now, decision on an individual basis for the patient, as to choice of therapy, radiation or chemotherapy, or just possibly a combination, must be made after adequate data for the patient is acquired. And for the future, Durant[6] in an editorial has stated it well, "we need data and sound experimental design on which to make judgments, not belief."—OVID O. MEYER, MD, Department of Medicine, University of Wisconsin Medical School, Madison

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Karl H. Doege, MD: 1892–1971

WITH THE PASSING of Karl H. Doege, MD on April 12, 1971, the medical community has lost one of its most dedicated doctors. Although a report of his death will appear in a future issue of the *Wisconsin Medical Journal,* it seemed appropriate that the Journal should acknowledge his passing in the editorial columns.

Doctor Karl, as he was affectionately called, was considered the dean of Marshfield's medical fraternity and one of Marshfield's most distinguished citizens. His remarkable career encompassed more than 50 years of practice as a member of the Marshfield Clinic which his father helped establish. Doctor Doege served as president of the State Medical Society of Wisconsin in 1948–1949. He also was editor of the *Wisconsin Medical Journal* from 1939 until 1948.

The Reverend Virgil E. Taylor of the First Presbyterian Church of Marshfield eloquently eulogized both Doctor Doege and the profession of medicine with these words: "When a doctor lays down his work, it is not like the passing of an ordinary citizen. He has held a special position and relationship in the community. He is not simply a public agent for the transaction of business, he is a friend. He deals not only with the simple external goods and needs of men—he holds the most sacred trust.

"Under his hand the strong man lies down upon the operating table in an unconscious sleep and trusts his life to the doctor's careful skill. To him the woman tells her deepest secrets and trusts implicitly in his faith and honor. He watches over our entrance and exits from the world. He is a family friend. His people feel that they own him. He is subject to their call day and night. How many times we have heard over the years and particularly in the last few days the comment that Dr. Karl was not only our doctor, he was our friend. There seemed to come from him something more than his medicine—it was his personality and his friendship to all people."

And the *Marshfield News Herald* in its editorial columns expressed the community's sentiments in a stirring appraisal: "Dr. Doege's competence as a physician was recognized far beyond the broad area in which he practiced, and the honors conferred upon him by members of the medical fraternity were many and well deserved. Yet it is probable that he will be remembered by most of those to whom he ministered as a friend, even more than as a physician.

"He had a unique quality of friendliness and of interest in people that endeared him to those whose lives he touched. Born and reared in an era of neighborliness and accustomed to the camaraderie of rural residents, he retained the common touch that is often lost by men of comparable education and attainments, and he conversed as easily with children and ordinary folk as he did with the more sophisticated inhabitants of the "other world" in which he also moved and was equally at home.

"In a period when the practice of medicine has become highly specialized and to a great degree impersonal, Dr. Karl Doege remained basically one of that vanishing breed, the "family doctor" who saw a patient as a person rather than a problem. Marshfield will not be the same without him." □

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Society Asks for Physician Assistant Experiment

An experimental program of certification for Physician's Assistants has been requested by the State Medical Society through introduction of Assembly Bill 707. The bill was jointly introduced by 56 representatives and 20 senators.

The proposal is the result of three months of concentrated research and conferences by the State Medical Society with physicians and representatives of nursing, dentistry, and other allied professions along with legislators and spokesmen for many state and voluntary health agencies.

In a statement of public policy, the intent of the bill is described as twofold:

1. Realizing a shortage of physicians and supporting health personnel, legislative recognition and regulation is extended on an experimental basis to a new category of health personnel to be called Physician's Assistants.
2. To safeguard the health of the public as this additional resource is made available by requiring those certified as Physician's Assistants to be regulated and supervised by the Board of Medical Examiners.

A key provision of the bill is that "no license, certification or registration shall be required for any individual to provide patient services under the direction and supervision of a permanently licensed physician providing no individual shall hold himself out as a 'Physician's Assistant' or use the initials 'P.A.' unless so certified by the examining board." This is legislative acknowledgment of the universally established professional and legal principle of delegation while requiring certification only of those who wish to use the title of Physician's Assistant.

Under the bill, there is created an 11-member Physician's Assistant Council to advise and report to the State Medical Examining Board. The council will develop and recommend certification standards and practice definitions including recognition of appropriate training programs for Physician's Assistants as experience indicates.

Another important aspect of the Society's bill is exemption from the statute of those people already licensed, certified or registered under Wisconsin laws as well as those who have recognition in various assistant categories certified by voluntary agencies such as the AMA.

The bill defines a Physician's Assistant as one qualified by general education, formal or informal training, experience and personal character to provide patient services under the direction and supervision of a permanently licensed physician.

Bill 707A proposes that a Physician's Assistant may be employed and his services billed "only by one or more physicians." He may not be self-employed.

A report of progress under the legislation is required no later than Dec. 31, 1973, and, unless extended by the Legislature, will expire on June 30, 1977. This termination date is designed to assure legislative review of the entire program at the end of five years.

A second bill dealing with the same subject has been introduced at the request of the Wisconsin

continued on page 30

ATTENTION

Physicians desiring a copy of the entire Physician's Assistant bill are urged to contact the State Medical Society headquarters, Box 1109, Madison, Wis. 53701. A copy of the bill with explanatory comments will be made available on request.

Physicians are urged to express their comments to representatives and senators in support of the Society sponsored bill 707A.

Old Fort Crawford Art Fair Set for June 27

The second annual Old Fort Crawford Art Fair is scheduled for Sunday, June 27, on the grounds of the Museum of Medical Progress and Stovall Hall of Health in Prairie du Chien.

Registration begins at 8:00 in the morning with the exhibit to end at 8:00 in the evening.

Some 800 artists, sculptors, and craftsmen have been extended invitations to exhibit paintings, graphics, jewelry, pottery, sculpture, textiles, enamels, wood and metal work, glass, and photography.

All items will be for sale by individual exhibitors.

The Art Fair is sponsored by the State Medical Society's Charitable, Educational and Scientific Foundation.

Hospital Accreditation Standards Published

The new *Accreditation Manual for Hospitals* is now available from the Joint Commission on Accreditation of Hospitals, according to an announcement by the Commission. As a result of the April 1 publication of the revised *Standards for Accreditation of Hospitals,* July 1, 1971, has been set as the date of their implementation as the basis for accreditation surveys.

The Commission began revision of the Standards in August 1966 with final approval by the Commission on Dec. 12, 1970.

Of particular interest to physicians are revised Standards pertaining to hospital medical staff representation on governing boards and potential establishment of clinical departments of general or family practice.

As adopted by the JCAH, the standards on medical staff representation state that where legally permissible physicians on medical staffs shall be eligible for and should be included as full members on governing bodies.

The revised Standards also state that medical staffs may establish clinical departments of general or family practice and assign responsibilities in keeping with functions desirable to meet organizational needs of the medical staff of the hospital, "including equal rights for representation on the executive committee of the medical staff."

They also state that "final responsibility for recommendations on clinical privileges and for review of cases shall, however, continue to reside in the applicable specialty departments."

In all, the manual includes 21 sections: an Introduction; an Administrative Policies section, outlining the accreditation program; a Glossary; a Preamble, describing patient's rights; sixteen sections of standards covering various aspects of the hospital's operation, and an Appendix, outlining the appeals mechanism.

Prices for the Manual, which has been published in two editions, are: $8.00 for the loose-leaf binder edition (includes a two-year updating service) and $2.25 each for one to five copies of the soft-cover, bound edition, $2.00 each for more than five copies. Order from JCAH, 645 North Michigan Ave., Chicago, Ill. 60611; tel. 312/642–6061.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal,* official publication of the State Medical Society of Wisconsin, to provide current news of socio–economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

Revised Press Guide Now Distributed

The State Medical Society recently distributed its revised edition of "Guide for Physicians, Hospitals and News Media" to editors of newspapers and managers of radio and television stations in Wisconsin as well as administrators of Wisconsin hospitals, all of whom helped in developing the unique guide to news relationships.

The Guide also was printed in the January 1971 Blue Book issue of the *Wisconsin Medical Journal.*

Additional copies may be obtained upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Wisconsin MDs and Wives Give AMA–ERF $19,432

Wisconsin physicians and their wives contributed $19,432.83 in 1970 to the American Medical Association Education and Research Foundation (AMA–ERF), according to a recent report of the Foundation.

This was $2,690.60 less than their contributions in 1969.

The wives, through the Woman's Auxiliary, gave $12,458.58 while the physicians gave $6,974.25.

PHYSICIAN ASSISTANT

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Legislative Council and is identified as Senate Bill 463. This bill is substantially identical to the State Medical Society's bill but is significantly different from the State Medical Society's proposal in two respects:

1. It contains no clarifying language as to the authority of physicians to delegate to persons they believe competent.
2. It does not provide adequate exemption from the Physician's Assistant certification program for those in allied health fields already certified or recognized.

Society representatives appeared at hearings in mid-May at which both bills were introduced. There is strong indication that the two bills will be combined into a mutually acceptable proposal in which the two elements mentioned above are made a part of the agreed legislation. The State Medical Society believes these elements are crucial to adequate legislation in a new field.

Attention! Physicians Over 70 Years of Age

The American Medical Association is reminding physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Active, regular, dues-exempt membership in the AMA can be arranged for eligible physicians by contacting the state medical society.

The AMA emphasizes that the physician must make the request to his state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by subscription.

Other AMA dues exempt classifications may be requested through the state medical society for the following reasons: financial hardship, illness, intern and resident training, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an affiliate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Society urges all physicians who are retired or will be retiring to advise the State Society of their present or future status so that a change in classification can be arranged.

Child Advocacy Council Proposed

Establishment of a child advocacy council as a statutory agency within the administrative offices of the Governor has been proposed by the Wisconsin Psychiatric Association.

Such a council would be charged with the responsibility of representing the child with special needs when state programs pertaining to children and adolescents are involved, the WPA proposal indicated.

The proposal also suggested that the council could serve as a consulting body to public agencies involved with "planning and programming" of child-related functions.

The child advocacy council would be composed of nine to 12 members drawn from professionals in the health, educational, legal, and social service fields in addition to the public, particularly the parents of children in need.

The WPA proposal also suggested that funds for the support of the council could be sought from the U.S. Department of Health, Education, and Welfare.

The WPA listed the following responsibilities of the proposed child advocacy council:

1. Advise the Governor on state programs pertaining to children and adolescents.
2. Design a blueprint for a child advocacy system in the state.
3. Study and evaluate regional and local health, educational, legal, and social services programs for children and adolescents.
4. Investigate and evaluate state health, educational, legal and social services programs for children and adolescents.
5. Create task forces charged to study and develop recommendations on topical issues.
6. Publish reports on the status of programs for children and adolescents in the state.
7. Through statutory legal standing participate in litigation designed to clarify responsibilities of the state to children and adolescents and to institute modifications and additions to state programs.

Wisconsin's Doctor Draft Quota Includes 31 MDs

The status of Wisconsin physicians eligible for the current draft call to military duty, which starts July 1, was reviewed by the State Medical Society's Committee on Military Medical Service and the Wisconsin State Advisory Committee to Selective Service, April 21 at SMS Headquarters in Madison.

After carefully reviewing the records of all eligible physicians, the Committee reported that all of this group could be subject to call.

The draft call will be made on the basis of age with the youngest eligible doctor to be called first, the second youngest next, on up to the age of 35.

Physicians and communities around the state have expressed their concern over the call by age since this group has the most potential for recruitment to practice in the areas where doctors are struggling with heavy work loads and communities are lacking adequate medical service.

MECO Program Participants Announced

There will be 18 pre-sophomore medical students from the two Wisconsin medical schools participating this summer in a ten-week extramural educational program known as MECO (Medical Education Community Orientation).

The MECO Program, co-sponsored by the State Medical Society of Wisconsin and the Student American Medical Association is designed to expose preclinical medical students to the community and the total scope of community health care delivery.

MECO students will be introduced to the clinical aspects of medicine as a reinforcement and motivational force as related to their medical school curriculum.

They will observe physicians and learn basic procedures in a community hospital and in the physicians' offices, rotating through a clinical program under direct supervision of a physician.

Participating hospitals, physicians, and students are shown in the accompanying chart.

Participants in MECO Program—1971

City	*Hospital*	*Physician-in-charge*	*Student*	*School*
Beaver Dam	Lutheran/St. Joseph's	John Szweda, MD	Gary Woroch	UW*
Black River Falls	Black River Memorial	Charles Aprahamian, MD	James R. Sanger	UW
Kaukauna	Kaukauna Community	George A. Behnke, MD	Bernie Micke	MCOW†
Kenosha	Memorial	Ray Welsch, MD	Charles Rogers	MCOW
Kenosha	St. Catherine's	Harold A. Bjork, MD	John Hron	MCOW
Lancaster	Memorial	Larry W. Johnson, MD	Ron Haumschild	MCOW
Medford	Memorial, Taylor County	Walther W. Meyer, MD	James W. Lundeen	UW
Menomonie	Memorial	F. A. Melms, MD	Rick Kark	MCOW
Mondovi	Buffalo Memorial	W. E. Wright, MD D. B. Johnson, MD	Patricia Day	MCOW
Platteville	Platteville Municipal	C. L. Steidinger, MD	Gerald Bayer	UW
Racine	St. Mary's	D. F. Cohill, MD	S. John Vindekilde	UW
Sparta	St. Mary's	Jack Brown, MD	Joe Langlois	UW
Stevens Point	St. Michaels	Thomas P. O'Malley, MD	Michael J. Kretz	UW
Superior	Holy Family	Robert Sellers, MD	Laurence D. Tempelis	UW
Viroqua	Vernon County	R. A. Starr, MD	Jeff Menn	UW
Waupun	Memorial	R. E. Schrank, MD	Jan Weber	UW
West Bend	St. Joseph's Community	Charles Geiger, MD	Ginger Michels	MCOW
Whitehall	Tri-County	O. M. Schneider, MD	Steve Lukowicz	UW

* University of Wisconsin Medical School, Madison
† Medical College of Wisconsin, Milwaukee

Gov. Lucey Boosts Museum's Ecology Exposition

More than 1,000 persons joined Governor Patrick J. Lucey and other state representatives in celebrating an Open House affair May 1 at the Old Fort Crawford Museum of Medical Progress in Prairie du Chien.

The event marked the start of "John Muir Ecology Week," proclaimed by the Governor.

The seven-day observance also was the start of a series of events which are being planned throughout the Museum's season to draw attention to the nation's first educational ecology exposition.

Honored guests attending in addition to the Governor were Vernon W. Thomson of Richland Center, third district congressman; Milo C. Knutson of La Crosse, state senator; and Bernard Lewison of Viroqua, state representative.

John Muir (1838–1914) was a native of Scotland but grew up on a farm near Montello, Wisconsin, and studied botany and geology at the University of Wisconsin. He once lived and worked in Prairie du Chien.

One of the leading naturalists and conservationists in the U.S., Muir is given major credits for the establishment of Yosemite and Sequoia National Parks.

The ecology exposition, called "Eco Expo," features some 25 specially prepared exhibits covering all aspects of environmental health problems. Included are displays on the recycling of paper products, a study of the Mississippi river, chemical pollution and control, automobile exhaust controls, solid waste disposal and atomic energy.

The exhibits feature positive measures to correct pollution of various kinds. A number of Wisconsin companies and colleges have contributed to the unique showing.

The historic Fort Crawford Medical Museum, a national registered landmark, and its adjoining Stovall Hall of Health are owned and operated by the Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin. "Eco Expo" is open daily from 8:00 a.m. to 5:00 p.m. through October 31.

PARTICIPATING IN PROCLAMATION CEREMONIES for "John Muir Ecology Week" May 1–7 were left to right: William D. Stovall, MD, president of the CES Foundation; Governor Patrick J. Lucey; Ambrose Locke, mayor of Prairie du Chien, and David Meyer, president of the Prairie du Chien Chamber of Commerce.

"Eco Expo" Exhibit Acknowledgment

The Society wishes to acknowledge the following for their efforts in behalf of the "Eco Expo" exhibit:

Aqua-Chem, Inc., Beloit College, Dairyland Power Cooperative, Ecology Student Association of University of Wisconsin–Madison, Forest Products Laboratory/Forest Service/USDA, FS Services Inc., Hydrite Corp., Institute of Paper Chemistry,

The Journal Company, Minnesota Mining and Manufacturing Company, Wisconsin Chapter of Nature Conservancy, Nelson Muffler Corporation, Oscar Mayer & Co., Prairie du Chien High School, Pure Way Corp., State Historical Society of Wisconsin,

Wisconsin Department of Natural Resources, Wisconsin Paper Industry Information Service, Wisconsin Petroleum Council, Wisconsin State University–Stevens Point, Wisconsin Tuberculosis and Respiratory Disease Association, Wisconsin Veterinary Medical Association, and Zimpro, Inc.

And a special thanks is extended to the people of Prairie du Chien and the organizations who wholeheartedly encouraged and supported the development of this exposition.

MDs Urged to Speed Up Signing of Death Reports

George H. Handy, MD, state health officer, has issued a plea to physicians for timely signing of death certificates.

The State Division of Health has reported instances of delays of three to four months in receiving death certificates, he noted.

Dr. Handy further stated that "delays in filing these certificates cause tremendous problems in terms of burial permits not being able to be issued, families not being able to complete negotiations with the insurance companies, and statistical information which is compiled from death records being inaccurate.

"All funeral directors in the state have been notified of their responsibility in making sure that these certificates are completed on time and properly. The funeral director is assuming a great deal of responsibility if he embalms and buries a body without an appropriate signature from a competent physician. In some cases it is reported that this is the only alternative he has."

Dimetapp Extentabs®

INDICATIONS: Dimetapp Extentabs are indicated for symptomatic relief of allergic manifestations of upper respiratory illnesses, such as the common cold, seasonal allergies, sinusitis, rhinitis, conjunctivitis and otitis. In these cases it quickly reduces inflammatory edema, nasal congestion and excessive upper respiratory secretions, thereby affording relief from nasal stuffiness and postnasal drip.
CONTRAINDICATIONS: Hypersensitivity to antihistamines of the same chemical class. Dimetapp Extentabs are contraindicated during pregnancy and in children under 12 years of age. Because of its drying and thickening effect on the lower respiratory secretions, Dimetapp is not recommended in the treatment of bronchial asthma. Also, Dimetapp Extentabs are contraindicated in concurrent MAO inhibitor therapy.
WARNINGS: *Use in children:* In infants and children particularly, antihistamines in overdosage may produce convulsions and death.
PRECAUTIONS: Administer with care to patients with cardiac or peripheral vascular diseases or hypertension. Until the patient's response has been determined, he should be cautioned against engaging in operations requiring alertness such as driving an automobile, operating machinery, etc. Patients receiving antihistamines should be warned against possible additive effects with CNS depressants such as alcohol, hypnotics, sedatives, tranquilizers, etc.
ADVERSE REACTIONS: Adverse reactions to Dimetapp Extentabs may include hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis and thrombocytopenia; drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, hypotension/hypertension, headache, faintness, dizziness, tinnitus, incoordination, visual disturbances, mydriasis, CNS-depressant and (less often) stimulant effect, anorexia, nausea, vomiting, diarrhea, constipation, and epigastric distress.
HOW SUPPLIED: Light blue Extentabs in bottles of 100 and 500.

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF APRIL 15, 1971

NEW MEMBERS

Beix, James R., 409 Spruce St., River Falls 54022
Cruz, Samuel J., 408 Mill St., Plymouth 53073
Gonzaga, Caesar R., 133 West Central St., Chippewa Falls 54729
Gonzaga, Fe Q., 133 West Central St., Chippewa Falls 54729
Kontra, Dennis J., 500 Walton Ave., Racine 53402
Lane, Larry R., 10 Quarterdeck, Madison 53705
Leclercq, Toussaint, University Houses 11A, Madison 53705
Sarkarati, Ebrahim, 408 South River St., Janesville 53545
Sierra, Jesus, 212 South 11th St., La Crosse 54601
Strickland, Samuel A., 2026 Todd Dr., Madison 53713
Thearle, Daniel S., 238 Little Rd., Green Bay 54301
Ullrich, Peter H., 727–29 Kenney Ave., Eau Claire 54701

CHANGE OF ADDRESS

Ackerman, Jack S., 7231 North Barnett Lane, Milwaukee 53217
Apte, Upendra S., P.O. Box 4973, Milwaukee 53215
Bachus, Arthur C., Route #2, Ripon 54971
Chelius, Carl-Juergen, 3533 East Ramsey Ave., Cudahy 53110
Clarke, B. Earl, 2019 East Shorewood Blvd., Milwaukee 53211
Cornell, John W., 3533 East Ramsey Ave., Cudahy 53110
Cron, Roland S., 324 E. Wisconsin Ave., Milwaukee 53202
Dittmer, Otto A., Jr., Route #2, Ripon 54971
Dorman, Thomas W., 3343 Douglas Ave., Racine 53402
Fine, Jacob M., 3533 East Ramsey Ave., Cudahy 53110
Grassey, Richard G., Jr., 20 South Park St., Madison 53715
Gregorio, Fernando Q., 8700 South Howell Ave., Oak Creek 53154
Hendrickson, Alvin O., 515—11th St., Wausau 54401
James, John R., 733 West Clairemont Ave., Eau Claire 54701
Kocovsky, Elmer C., P.O. Box 596, Elm Grove 53122
Lando, David H., Jr., 3533 East Ramsey Ave., Cudahy 53110
Landsberg, Manfred, 3067 South Superior St., Milwaukee 53207
Matzke, Robert F., 1200 Home Park Ave., Janesville 53545
Moland, Oscar G., P.O. Box M., Augusta 54722
Montgomery, Robert P., 811 East Wisconsin Ave., Milwaukee 53202
Nemeth, Charles, Box C: Clinical Services, Waupun 53963
Nordby, Eugene J., 2704 Marshall Court, Madison 53705
Palisoc, Jose M., Jr., 4819 South Packard Ave., Cudahy 53110
Peterson, Myron D., 2704 Marshall Court, Madison 53705
Potos, William B., 3533 East Ramsey Ave., Cudahy 53110
Querimit, Alberto S., N84 W16889 Menomonee Ave., Menomonee Falls 53051
Ravn, Erling O., 716 East 2nd St., Merrill 54452
Rundle, Frank L., 140 West Franklin, Monterey, Calif. 93940
Sachtjen, Kenneth M., 2704 Marshall Court, Madison 53705
Saxe, Jack J., 151 East Cook St., Portage 53901
Shearer, Charles E., 1011 North Main St., Edgerton 53534
Sirin, Kirim F., 3533 East Ramsey Ave., Cudahy 53110
Stein, Paul G., 12320 St. Martins Rd., Franklin 53122
Tabet, Robert C., 3533 East Ramsey Ave., Cudahy 53110
Thieda, Edwin S., P.O. Box T, Augusta 54722
Watt, Thomas L., 810—19th Ave., Monroe 53566

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COUNCIL MINUTES

MADISON, NOVEMBER 14, 1970

1. Call to Order and Roll Call

The Council was called to order at 1:50 p.m. by Chairman Nordby at the State Medical Society.

Voting members present: Doctors Schrank, Galgano, Davenport, Nordby, Edwards, Smejkal, Dettmann, Mauthe, Rohde, Boren, Manz, Doyle, Chojnacki, Foley, Schmidt, Egan, Wright, Past President Callan, President McRoberts, and Speaker Nereim.

Officers and others present: President-elect Behnke, AMA delegates Bell, Galasinski, and Hildebrand; alternate delegates Kief, Collentine, Russell, and Carlson; Doctor Simenstad; Doctor Bein, Racine, and, for special order, Doctor Cullen of Fond du Lac; Messrs. Crownhart, Thayer, Koenig, Brower, Reynolds, Maroney, McIntyre, Doran, Lockerbie, Brown, LaBissoniere, Murphy, Kluwin, G. W. Crownhart, Gill, Tiffany; Misses Cordts and Pyre.

2. Approval of Minutes

On motion of Doctors Chojnacki–Mauthe, carried, minutes of the July 31–August 1, 1970, Council meeting were approved.

3. 1971 Annual Meeting

The Executive Committee reported finalization of plans by the Commission on Scientific Medicine for housing of the scientific program and exhibits in the Sheraton–Schroeder, approved as an experiment for 1971.

A proposed schedule of business and social events at the Pfister Hotel, with a minimum of conflict with the scientific sessions, was presented to the Council and approved on motion of Doctors Foley–Galgano, carried.

4. Commission on State Departments

(a) Division on Nervous and Mental Diseases

Doctor Cullen, president of the Fond du Lac County Medical Society, was present at the request of the Division to discuss the local concern over appropriate physician direction of the community mental health center. It was recommended that guidelines be established, for the benefit of all communities of the state, including a requirement that the clinical director, regardless of title or of other administrative positions, be a physician and preferably a board certified psychiatrist. The Council was asked to take this position in advance of an anticipated meeting of the Division with representatives of the State Division of Mental Hygiene on overall guidelines.

Following discussion, and on motion of Doctors Chojnacki–Dettmann, carried, the Council recommended to the Board of Health and Social Services that it implement guidelines for community mental health centers that would include having a physician and preferably a psychiatrist as the director where possible.

(b) Preschool Vision and Hearing Screening

Mr. Maroney reported on a meeting of the chairmen of the Divisions on Vision and on Ear, Nose and Throat, representatives of the Woman's Auxiliary, the State Department of Public Instruction, and the Wisconsin Society for the Prevention of Blindness, at which the preschool screening program as conducted in Minnesota was presented. The Auxiliary has recommended that the Society sponsor a statewide screening program to the extent it is not now being done by state agencies and private organizations. County auxiliaries are now doing the testing in some areas of the state. The chairmen of the two Divisions of the Commission on State Departments recommended that the Council approve a coordinating effort for a statewide screening program using existing programs as a basis for review.

On motion of Doctors Chojnacki–Foley, carried, the Council commended the Auxiliary and suggested that the Commission seek its assistance in this matter.

(c) Central Registry for the Handicapped

On motion of Doctors Schmidt–Boren, carried, the Council approved the recommendation of the Commission on State Departments that the Society not sponsor establishment of a state-operated central registry in the belief that such a registry would operate best if it were voluntary.

(d) Resolution on Employment of Cardiac Handicapped

On motion of Doctors Egan–Chojnacki, carried, the Council approved the following resolution recommended by the Division on Rehabilitation which relates to the work of Doctor Hellmuth of Milwaukee:

"WHEREAS, The prevalence and distribution of cardiovascular disease in industry is an impediment to the health of the work force; and

"WHEREAS, Many capable cardiac workers have difficulty in obtaining employment; and

"WHEREAS, The medical profession recognizes that most cardiac cases when rehabilitated and selectively placed are efficient and productive workers; and

"WHEREAS, There is no scientific evidence that work per se can etiologically cause organic disease; therefore be it

"*Resolved,* That the State Medical Society of Wisconsin study and implement ways and means of improving the employment status of the cardiac worker; and be it further

"*Resolved,* That the State Medical Society of Wisconsin communicate these facts to its members, and urge leadership of the medical community (medical schools and professionalism) and effective action on the state level by cooperation with the legal profession, organized labor, industry, workmen's compensation administrators, insurance carriers, health workers, and other interested groups."

5. Commission on Hospital Relations and Medical Education

(a) Community Achievement Award

On motion of Doctors Edwards–Foley, carried, the Council approved the recommendation of this Commission that individual councilors submit nominations of a hospital or hospitals in their areas which they feel warrant consideration for receiving the community achievement award, and that they be classified as small, under 100 beds, and large hospitals.

(b) Supply of Physicians

The Council discussed a position paper on "Health Manpower in Wisconsin in the 1970's" which had been forwarded by the Executive Committee of the Council,

but which also had been reviewed by the chairman of this Commission and the chairman of the Special Committee on the Shortage of Physicians.

A motion by Doctors Foley–Callan, carried, that the paper include strong encouragement to increasing the number of Wisconsin residents admitted to the two medical schools in Wisconsin, and that retention statistics in this regard be incorporated.

Certain other editing was suggested by councilors, and on motion of Doctors Mauthe–Foley, carried, the paper was accepted as amended for presentation to the Legislative Council Advisory Committee on Medical Education.

The Council also received copy of a letter to the University of Wisconsin Medical Center Task Force which had invited comments from the Society on the function and operation of the medical school in the organizational structure of the Medical Center as a whole.

6. Council Committee Reports

(a) Executive Committee

The Council had received minutes of the committee meeting of September 30. The following items were presented specifically for Council action, in addition to the position paper on health manpower:

(1) Appeal from County Society Expulsion Action

A member expelled by his county society had appealed to the State Society. The Executive Committee recommended, as agreed to by appellant, that it be delegated authority to act as the appeal body rather than the entire Council.

On motion of Doctors Egan–Foley, carried, the Council approved the recommendation as an exception to the bylaws. Doctor Mauthe asked that his negative vote be recorded.

(2) Washington State Medical Disciplinary Board

On motion of Doctor Chojnacki, seconded and carried, the Council approved the recommendation that this be investigated with a view to possible introduction of legislation in Wisconsin to create such a board for all physicians of the state.

(3) Certificate of Need Legislation

On motion of Doctors Egan–Smejkal, carried, the Council agreed that the Society should oppose in its present form proposed legislation authorizing comprehensive health planners to issue certificates of need for prior approval for the establishment of hospitals, nursing homes, and other health care institutions relating to building construction, additions or modifications of services or facilities by such institutions.

The Executive Committee reported further on its meeting the morning of November 14:

(4) Proposed Home Tranfusion Program for Wisconsin Hemophiliacs

The committee discussed a proposal from the Wisconsin Chapter of the National Hemophilia Foundation for a program of home transfusions for its members residing in isolated areas of the State. It felt that while the mechanics of providing such a service might be worked out, there are rather serious medical–legal problems involved, and the committee has asked legal counsel for advice.

On motion of Doctors Chojnacki–Smejkal, carried, the Council accepted this report.

(5) Wisconsin Medical Journal

On motion of Doctors Wright–Foley, carried, the Council approved the committee recommendation that Wisconsin decline a proposal for joint printing with other north central states of a section common to all the journals containing scientific articles and national advertising. It was believed that any actual savings in printing costs would be offset by administrative problems.

(6) Military Experience Directed Into Health Careers

The committee reported proposed implementation of this program through the Wisconsin Health Council, with an administrator to be employed and housed at the Society, but salary and related expense will be reimbursed. The purpose of the program is to assist servicemen and women trained in medical skills while in service to find a career in the health field upon return to civilian life. The committee recommended Council approval in the understanding that technical personnel expected to be utilizing this program are not in the nature of the physician assistant.

On motion of Doctors Mauthe–Foley, carried, the Council approved the MEDIHC program, while in no way discouraging development of the physician assistant.

(7) Complaint Against Society Member

On motion of Doctor Egan, seconded and carried, the matter was referred to the local county medical sociey for prompt consideration.

(8) Disputed Provident Claim

Doctor Sullivan and Mr. Kluwin had been asked to review the facts of the dispute with the Milwaukee physician concerned and with the insurance company. It was their joint conclusion that they could not recommend either that the claim be paid or denied, but did recommend that the physician submit it to arbitration as provided in the contract.

On motion of Doctors Wright–Chojnacki, carried, the Council accepted the recommendation.

(9) Society Management Starting January 1, 1971

The Executive Committee presented the following statement to the Council:

"After nearly 30 years of continuous, dedicated and highly effective service as secretary and general manager of the State Medical Society of Wisconsin, Mr. Crownhart is announcing his retirement from such duties as of December 31, 1970. In order to utilize his good judgment and experience and to aid in the transfer of the management of SMS and its activities, it is recommended that Mr. Crownhart be appointed as a consultant on a per diem to be negotiated.

"Further it is recommended:

"1. That Earl Thayer as of January 1, 1971, be elected as secretary and general manager.

"2. Consistent with Council policy relating to the position of general manager, as enunciated in 1950 and since followed, Mr. Thayer shall have primary responsibility for the day to day operations of the Society and all of its special functions and affiliated organizations, exclusive of those noted in item (3) which follows. His authority will include the management of the Society and its affiliates within established policies; also operating them within budgets to be established for 1971.

"3. In the case of WPS, the managerial responsibilities of the Insurance Director, Mr. Koenig, as set out in a letter to him from Mr. Crownhart, dated July 16, 1970, be continued. It is emphasized that the authority of the Insurance Director, which is a delegation of part of the responsibilities of general management, is 'subject to the policy decisions of the Commission on Medical Care Plans and the Council.' The Insurance Director shall communicate with the general manager to permit the latter's informed re-

porting required in his function and to allow an overview of the financial operations and of the personnel practices and compensation of WPS so as to insure consistency with Society policies and with the operation of other Society activities and functions."

On motion made, seconded and carried, the statement as originally presented was adopted with the words "communicate with" in the third sentence of the third numbered paragraph being changed to "report to."

(10) North Central Conference

On motion of Doctor Manz, seconded and carried, the Council agreed with the Executive Committee that Indiana would be welcome as a member of the conference.

(11) 1970 Actions of House of Delegates; Fiscal Notes

The committee received a report on the status of projects requiring specific financing, and noted that most if not all actions of the House involve time of staff and committees. The committee recommended to the Council that henceforth existing policy be enforced that committee reports recommending new projects must bear a fiscal note, and further, that resolutions introduced by county societies have a fiscal note when indicated. It is recognized that the latter will need review by the Council in advance of House consideration to assess their realism.

On motion of Doctors Egan–Chojnacki, carried, the recommendation on fiscal notes was approved.

(12) President-designate of University of Wisconsin

On motion of Doctor Wright, seconded and carried, the Council agreed that an invitation be extended for an informal dinner meeting with the new University President, preferably in conjunction with a Council meeting.

(13) Past Presidents Committee

The Executive Committee recommended that the Past Presidents be utilized in an advisory capacity as matters arise in which they have a particular interest or experience, rather than continuing a Past Presidents Committee per se. There was no disagreement with this.

(b) Finance Committee

Doctor Dettmann reported on budget performance review by the committee, which indicated operations are pretty much on target although Journal income is below that anticipated. The total expense for the Work Week of Health is well below budget, and the committee recommended that when feasible in the future, a registration fee be charged to cover at least the cost of food. The Journal will be mailed without a wrapper at a monthly savings, and it is hoped that part of the time of one of the two Journal employees can be reallocated to other functions.

On motion of Doctors Chojnacki–Smejkal, carried, the report of the Finance Committee was accepted.

7. Commission on Safe Transportation

(a) Division of Motor Vehicles—Medical Report Form

An informational progress report was received that the Commission is continuing discussions with state department representatives on a revision of the form currently in use.

(b) Tractor Safety

Also for information, the Council was advised that this Commission, and the Committee on Occupational Health, both have recommended that the Society support legislation which would require the use of roll bars and seat belts on tractors. The Commission on Public Policy is inclined to the view that safety education would be preferable to legislation, but will meet with representatives of both committees to hear their viewpoints.

8. Ad Hoc Committee on the Medical Practice Act

Doctor Russell informed the Council on the status of proposals under consideration in reference to licensing or certification of ancillary personnel. There will be a later report on proposed legislation. He also indicated that the AMA has suggested that the states withhold proposals as to the physician assistant until after the clinical convention.

9. Commission on Medical Care Plans

(a) Health Care Delivery Systems

Mr. Koenig discussed the several forms of group practice and the advantages and disadvantages claimed for each. He gave examples of closed panel plans and of the foundation approach. He had also made a survey of the Blue plans and commercial companies indicating that with few exceptions, there is much study in progress but little to report by way of actual installations. WPS has one of the few experimental plans in operation at Wild Rose, as outlined to the Council at its last meeting.

Members of the Council urged that establishment of a foundation be seriously considered. It was pointed out that the Commission has a subcommittee on group practice, and that the general subject has been assigned to the Planning Committee of the Council.

(b) Nonmedical Members of the Commission on Medical Care Plans

On motion of Doctors Chojnacki–Mauthe, carried, the Council confirmed that in authorizing the appointment of five nonmedical, public representatives, it was intended that they be regular voting members of the Commission on Medical Care Plans.

The chairman noted that with the president and president-elect, there are now thirty-two members on the Commission, and he felt this number should be decreased as terms expire.

10. Work Week of Health

Mr. Thayer distributed a report on highlights of the 1970 Work Week and reported tentative plans for 1971 on the general theme of "Health Care—Can We Put It All Together." He will discuss details with the Executive Committee, but contemplates a program carried to various parts of the state in cooperation with interested county societies. The dates of October 17–23 are tentatively scheduled.

11. Medical College of Wisconsin

On motion of Doctors Foley–Chojnacki, carried, the Council forwarded a suggestion to the board of directors of the Medical College of Wisconsin that serious consideration be given to incorporating the name "Marquette" in the name of the medical school.

12. Adjournment

The Council adjourned following an executive session at 5:30 p.m.

C. H. Crownhart
Secretary

Approved:
E. J. Nordby, MD
Chairman

□

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SECTION OPHTHALMOLOGY

MAY 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

MEDICAL AND SURGICAL MANAGEMENT OF VIRAL KERATITIS

CLINICALLY THE MOST IMPORTANT viral keratitis is due to herpes simplex—a DNA virus for which we now have available for clinical use a specific antiviral agent—iododeoxyuridine (IDU). IDU, however, is not an ideal agent, and the search for more potent agents has continued by screening potential antiviral agents using tissue culture systems and the in vivo rabbit herpetic keratitis model. Promising new drugs recently reported on, and investigated by our laboratory have been trifluorothymidine (F_3TDR), adenine arabinoside (ARA–A), cytosine arabinoside (ARA–C), and rifampicin.

F_3TDR is more potent than IDU in rabbits, and no toxicity has been evident in humans. It is currently being evaluated double-blind in humans by other investigators. ARA–A is as effective as IDU in superficial herpetic keratitis, but an advantage is that when it is metabolized to the hypoxanthine it still maintains antiviral activity, unlike IDU which is rapidly metabolized to an inactive form. ARA–A has demonstrated no significant toxicity, and may even hold promise in systemic herpes simplex infections since the hypoxanthine has some antiviral effect. Ocular penetration of ARA–A also seems to be better than IDU and it may be more effective in deep stromal herpetic keratitis and uveitis. ARA–C is a very potent drug, but toxicity limits its usefulness. Rifampicin has good in vitro activity against vaccinia, but it has been disappointing in vivo in both vaccinial and herpetic infections. It has a good therapeutic effect against trachoma both in tissue culture and in animals. In vaccinial keratitis IDU has only a weak therapeutic effect, while F_3TDR and ARA–A are both much more potent agents.

Clinical indications for the use of the clinically available agent, IDU, consist of certain forms of herpetic keratitis (where multiplying virus is likely), vaccinial keratitis, and varicella zoster keratitis. Prophylactic "UMBRELLA THERAPY" with IDU is indicated in herpetic keratitis after penetrating keratoplasty, when corticosteroids are utilized. Umbrella therapy with IDU in steroid-treated herpetic stromal keratitis significantly reduces the recurrence incidence in humans, as compared to patients with corticosteroid-treated stromal keratitis who do not receive IDU concomitantly. Patients with zoster uveitis receiving topical corticosteroids should also receive IDU to hopefully minimize secondary infections with herpes simplex, which they are prone to.

IDU administration is contraindicated in Thygeson's keratitis since it may produce permanent corneal opacities. Toxicity may be seen after long-term use of IDU in the form of follicular conjunctivitis or closure of the punctum, both which abate after IDU is discontinued. In cases of severe toxicity a pseudo-trachoma picture may develop. Approximately 3% of patients cannot tolerate its use because of allergic reactions.

Penetrating keratoplasty is the procedure of choice in a quiet eye with a herpetic corneal leukoma when good vision is needed. Lamellar keratoplasty may be resorted to if one can remove all the diseased tissue and vascularization is not a problem; but usually visual results are much less satisfactory than with penetrating keratoplasty.

Occasionally a corneal ulcer may perforate. The purpose of any treatment in such a case is to restore the integrity of the cornea and anterior chamber to prevent synechiae and glaucoma. Small corneal perforations may close after a trial of pressure patching. Larger perforations may be closed with tissue adhesive or a "blow-out" patch. The perforation can be sealed in 90% of patients with careful application of isobutyl cyanoacrylate tissue adhesive. The remainder who fail can be sealed surgically with a "blow-out" patch of Tenon's capsule or cornea. After active inflammation has decreased a penetrating graft may be done. Total conjunctival flaps are contraindicated in corneal perforations although partial or bridge flaps may be useful.

Certain aspects of the therapeutic uses of tissue adhesives and hydrophilic contact lenses were also discussed and will not be detailed.—ROBERT A. HYNDIUK, MD

Summary of presentation before the Milwaukee Ophthalmological Society, March 23, 1971, Milwaukee. Doctor Hyndiuk is presently a Research Fellow, Department of Cornea Research, Retina Foundation, and a Clinical Fellow, Cornea Service, Massachusetts Eye and Ear Infirmary, Boston, Mass. He will be joining the staff of the Medical College of Milwaukee (Marquette) in July.

DR. STEVENS TO START FELLOWSHIP

Thomas Stevens, MD will start a one-year fellowship in external disease at the Francis I. Proctor Foundation, San Francisco, Calif., beginning July 1. Doctor Stevens will complete his ophthalmology residency at the Medical College of Wisconsin in June. □

NEWS HIGHLIGHTS

Wisconsin to Host Medical Clinics

The American Association of Medical Clinics, with headquarters in Alexandria, Va., will hold its North Central Regional Meeting July 17 at the Holiday Inn in La Crosse, Wis.

The Gundersen Clinic, with program chairman Adolf Gundersen, MD,* will sponsor the July 16 social meeting and the July 17 business and scientific sessions.

Timely and informative presentations concerning group practice operations will be given by authorities in the field. Vernon Wilson, MD, director of Health Services, Mental Health Administration, HEW, is scheduled to discuss the HMO concept.

Physicians in group practice and those interested in group practice are invited to attend the scientific session.

A total of 91 AAMC member clinics are represented in the nine states and Canada which comprise the North Central Region. They are: Canada, Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, South Dakota, and Wisconsin.

Vienna Medical Seminars "Angel" Succumbed

The WMJ office recently received word of the death of Mrs. Anna Rang–Engel (Angel) on Jan. 10, 1971, in Vienna, Austria.

She will be remembered in Wisconsin by a number of physicians who have studied in Vienna where she was the guiding force in the postgraduate seminars conducted by the American Medical Society of Vienna and the University of Vienna.

Following her heart attack in 1960, hundreds of American physicians and surgeons joined to establish an "Angel Fund." From this fund a portrait of "Angel" was made and placed in the American Medical Society office.

The "Angel Fund" continues to provide a fitting memorial for her and monies from this fund will be used to assure constant floral decorations on her grave.

Contributions can be made to "Angel Fund," % American Medical Society of Vienna, Vienna I., Universitatsstrasse 11, Austria.

Dr. Perlson New President Milwaukee Gynecologists

Samuel G. Perlson, MD* of Milwaukee was installed as president of the Milwaukee Gynecological Society at its annual meeting, March 29, at the University Club in Milwaukee.

Named president-elect was William W. Baird, MD* of Milwaukee. He will assume the presidency in 1972.

William A. Kretzschmar, MD* of Whitefish Bay was reelected secretary–treasurer.

The Milwaukee Gynecological Society, founded in 1951, has a membership of 122 board eligible surgeons in the specialty of obstetrics and gynecology in Wisconsin. Meetings are held at the University Club in Milwaukee on the second Tuesday of October and November and the second Monday of February, March, and April.

The Society's address is: 2825 N. Mayfair Road, Milwaukee, Wis. 53222.

Dr. Kerrigan Appointed V-P, Medical College

At a recent meeting of the Board of Directors of the Medical College of Wisconsin in Milwaukee, it was announced that the Board had appointed Gerald A. Kerrigan, MD,* to the new position of vice-president of the Medical College. Dr. Kerrigan also is dean of the Medical College.

Also reelected to a six-year term as Board member was another Milwaukee physician, Leo R. Weinshel, MD.*

PHYSICIAN BRIEFS

Charles Benkendorf, MD*

. . . Green Bay, recently was honored for his outstanding work in medicine and for his contribution to radiology by being named a Fellow of the American College of Radiology. He is a 1946 graduate of Marquette University School of Medicine (Medical College of Wisconsin) and is affiliated with St. Vincent and Shawano Community hospitals.

Enrique Villalobos, MD

. . . Beaver Dam, recently began his medical practice in Beaver Dam and is a staff member of St. Joseph's Hospital and Lutheran Hospital. He also is on the staff of Waupun Memorial Hospital. Doctor Villalobos took his internship at Illinois Masonic Medical Center and the University of Illinois Research Hospital, Chicago.

Thomas Wall, MD*

. . . Mequon, and Robert Goldberger, MD,* Fox Point, recently opened offices in Port Washington. They are associated with the medical staff at St. Alphonsus Hospital. Doctor Wall has been an assistant professor of surgery at the Medical College of Wisconsin and Doctor Goldberger was a clinical instructor in surgery at the medical college.

Vincent W. Nordholm, MD*

. . . Stoughton, recently was elected president of the Skaalen Sunset Home in Stoughton.

Marciano Visaya, MD*

. . . Pewaukee, recently opened offices in Pewaukee. He is on the medical staff of Elmbrook and Waukesha Memorial hospitals. Doctor Visaya, a native of the Philippines, came to this country in 1959 and has spent most of his time in the United States in the Milwaukee area.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

State Lab Expands Hematology Services

The Pathology Section of the State Laboratory of Hygiene, in the December 1970 issue of LABORATORY NEWSLETTER, announced the expansion of its consultative services in hematology starting January 1, 1971.

The NEWSLETTER announcement stated that consultation will be provided primarily to physicians' offices, for diagnosis of unusual hematologic disorders. Clinics, public health facilities, and small hospitals also may avail themselves of this program.

It is to be emphasized that the Special Hematology Unit will not perform tests routinely, but only when problems in diagnosis arise, the NEWSLETTER pointed out.

Operation of this new service is made possible by the addition of two experienced hematologists to the staff of the Laboratory Evaluation Program. They will work with MDs Dorothy Rosenthal and S. L. Inhorn,* and other members of the Pathology Section.

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New Diagnostic Cancer Test Developed at UW Medical Center

A new diagnostic tool that may eliminate many deaths from uterine cancer is being developed at the University of Wisconsin Medical Center by Judith Ladinsky, PhD.

Dr. Ladinsky's new test holds promise of being a superior technique to the widely-known Pap test for cancer. Its superiority lies in the earlier diagnosis of cancer; the Pap test detects cancer of the cervix while the Ladinsky test detects it at the uterus.

An additional advantage of this National Institutes of Health-supported project is that many more women could be tested with the number of specialized technicians now available, because much of the sample processing is automated.

The new test is already being used in Wisconsin clinics and the State Division of Health Mobile Unit.

Med. College Studies Carbon Monoxide As Air Pollutant

The Medical College of Wisconsin announced recently that it had begun a study of blood samples taken from 40,000 people in 15 of the nation's largest cities to find out how harmful carbon monoxide is as an air pollutant.

The study is being financed by $278,255 from the US Public Health Service and the Coordinating Research Council of New York.

Richard D. Stewart, MD,* head of the medical school's environmental medicine department, is directing the study.

New Surgery Chrm. for Medical College

A widely known Cleveland cancer surgeon has been appointed as professor and chairman of the Medical College of Wisconsin's Division of Surgery, according to an announcement April 14 by Gerald A. Kerrigan, MD,* dean of the College.

He is Jerome J. DeCosse, MD, PhD, who currently is professor of surgery at Case Western Reserve University School of Medicine, Cleveland, Ohio.

The Milwaukee County Board of Welfare also has approved Dr. DeCosse as director of Surgery for Milwaukee County General Hospital.

Dr. Kerrigan said that Dr. DeCosse will begin work at both the Medical College and County Hospital July 1.

Dr. DeCosse succeeds the late Edwin A. Ellison, MD, as head of the College's and Hospital's surgery departments.

Joseph C. Darin, MD,* has been acting chairman of the department since Dr. Ellison's death a year ago.

Dr. DeCosse is known for his work in clinical cancer surgery and cancer research, particularly in the biology of cancer cells.

Prior to joining the surgery faculty at Case Western Reserve, Dr. DeCosse was assistant professor of surgery and cancer coordinator, State University of New York School of Medicine, N.Y., 1963–1966.

In 1962–63, he was an assistant in surgery at Cornell University Medical College, New York City, and in 1955–56 he was the Henry Yates Fellow in Experimental Surgery, Sloan Kettering Institute, New York City.

Dr. DeCosse is a native of North Dakota. He received his degree in medicine from the University of Minnesota. He also holds a PhD degree in anatomy from State University of New York, Upstate Medical Center, Syracuse.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF APRIL 1971

6 Madison Chapter, Administrative Management Society
6 Madison General Hospital Surgical Staff
6 Madison Urological Society
6 Madison Anesthesiology Society
6 Dane County Medical Society Board of Trustees
8 Preceptors and Faculty, University of Wisconsin Medical School
8 SMS Committee on Government Contracts
12 State Pharmacy Board Exams
12 Dane County Medical Society Utilization Review Plan
12 Madison District Licensed Practical Nurses Association
13 National Board Exams, Senior Students, University of Wisconsin Medical School
14 National Board Exams, Senior Students, University of Wisconsin Medical School
17 SMS Maternal Mortality Study Committee
17 SMS Division on Maternal and Child Welfare
21 SMS Committee on Military Medical Service and State Advisory Committee to Selective Service
21 State Medical Examining Board
21 Madison Area Radiological Study Group
22 State Medical Examining Board (Reciprocity Exams)
23 MEDIHC Operating Committee
24 Wisconsin Society of Cytology
24 SMS Commission on Health Information
28 SMS Committee on Grievances

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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Harold F. Ibach, MD*

. . . of Milwaukee was honored recently for his outstanding work in medicine and for his contribution to radiology by being named a Fellow of the American College of Radiology. Dr. Ibach is affiliated with St. Michael Hospital in Milwaukee. He is a 1951 graduate of the University of Wisconsin Medical School.

Thomas H. Browning, MD

. . . Madison, recently became associated with the Odana Medical Center. A specialist in internal medicine and gastroenterology, Doctor Browning took his internship and specialty training in internal medicine at the University Hospitals, Madison.

Alfonso L. Tiu, MD

. . . formerly of New Berlin, recently opened offices in Palmyra. His wife, Lu, also a physician, will assist him on a part-time basis. Doctor Tiu recently completed his residency at Springfield, Mass. In July, Doctor Tiu will be joined in practice by Ernie Buencamino, MD.

William W. Grover, Jr., MD*

. . . Bonduel, recently was elected president of the Northeastern Wisconsin Health Planning Council. Doctor Grover succeeds Dr. John Dettmann,* Green Bay. Physicians to represent counties for five-year terms as council board members are: MDs George Shinners,* Green Bay, Brown County, and Robert Keller,* Sheboygan, Sheboygan County.

J. D. Farrington, MD*

. . . Woodruff and Minocqua, participated in the National Symposium on Emergency Medical Care—To Develop a Model Program for Emergency Medical Services in Metropolitan Areas on May 6–7 in Philadelphia. He was moderator of a workshop entitled "The Developing Role of the Ambulance Attendant (Emergency Medical Technician—Ambulance)." The symposium was sponsored by the Delaware Valley Council of the American College of Surgeons and cooperating organizations. Dr. Farrington is a member of the Committee on Trauma of the American College of Surgeons.

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Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon®).
Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.
USE IN CHILDREN: The safe and effective use of this drug in children has not been established, therefore, the physician must weigh the benefits against the potential hazards.
Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.
Adverse Reactions: Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.
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Hofmeisters Return from West Indies

The F. J.* Hofmeisters of Elm Grove recently returned from Kingston in the West Indies where they served aboard the famed hospital ship, SS HOPE, there on a ten-month mission.

"This experience has been rewarding for us not only in the delivering of health care but also because it revitalizes our awareness of how fortunate we are to be part of HOPE and also be Americans," said the obstetrician and gynecologist upon his return.

"Medicine and the giving of medical care is the universal language of compassion which unites people of all ethnic groups the world over," Dr. Hofmeister remarked. It was with this thought in mind that he and Mrs. Hofmeister volunteered for HOPE. They served as volunteers with HOPE for two months ending March 15. During that time he was on leave as associate clinical professor at the Medical College of Wisconsin in Milwaukee.

On the ship Dr. Hofmeister served as one of the more than 20 doctors and other specialists. His wife, Jane, worked full time as aide and receptionist with the x-ray department.

When asked about his service on the ship, Dr. Hofmeister replied, "I hoped in my own way to be of service, to alleviate the needs in Jamaica, and at the same time, reinforce the medical and paramedical programs of HOPE. The two main problems in Jamaica are manpower and facilities. To help with this problem, I was scheduled for 16 conferences and lectures and two operating days a week. I had two students assisting who went on rounds with me. I also attended clinics on shore, lectured to students, and had conferences with residents."

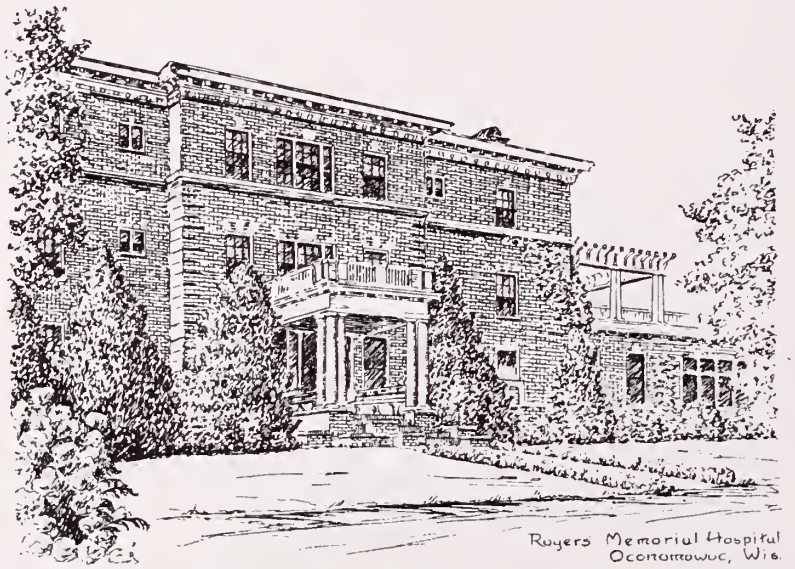
The hospital ship SS HOPE began her second decade of service when she arrived in Kingston to begin a ten-month teaching/treatment mission. The West Indies is the first phase of a three-year hemispheric program, with missions to follow to Brazil in 1972 and Venezuela in 1973.

Project HOPE, which sponsors these programs, is the principal activity of The People-to-People Health Foundation, Inc., an independent, non-profit international health organization, headquartered in Washington, D.C.

Cancer Grants Awarded Milwaukee Scientists

Seven cancer research grants totaling $38,892 have been awarded to Milwaukee scientists by the Milwaukee Division of the American Cancer Society.

Grants went to the following members of the Medical College of Wisconsin: Rene J. Duquesnoy, PhD, assistant professor, department of microbiology, $6,000; Sidney E. Grossberg, MD, professor and chairman, department of microbiology, $3,564; John C. Garancis, MD, associate professor, department of pathology, $3,000; Anthony V. Pisciotta, MD,* professor of medicine, department of medicine–hematology, $12,390 and Robert G. Kemp, PhD, associate professor, department of biochemistry, $3,500.



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Description: Proloid (thyroglobulin) is obtained from a purified extract of frozen hog thyroid. It contains the known calorigenically active components, sodium levothyroxine (T_4) and sodium liothyronine (T_3). Proloid (thyroglobulin) conforms to the primary USP specifications for desiccated thyroid—for iodine based on chemical assay—and is also biologically assayed and standardized in animals.

Chromatographic analysis to standardize the sodium levothyroxine and sodium liothyronine content of Proloid (thyroglobulin) is routinely employed.

The ratio of T_4 and T_3 in Proloid (thyroglobulin) is approximately 2.5 to 1.

Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications: Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication: Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings: Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid, and dosage should be started at a very low level and increased gradually.

Precaution: As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions: Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration: Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Instructions for Use: The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

Dose of Proloid (thyroglobulin)	Dose of desiccated thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

Overdosage Symptoms: Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied: ¼ grain; ½ grain; scored 1 grain; 1½ grain; 3 grain; and scored 5 grain tablets, in bottles of 100 & 1000; and scored 2 grain tablets in bottles of 100.

Warner-Chilcott, Morris Plains, N. J. 07950

SOCIETY RECORDS

continued from page 37

DEATHS

Weissbrenner, Mabel F., nonmember, Mar. 2, 1971
Meili, Emmet A., Trempealeau–Jackson–Buffalo County, Mar. 8, 1971
Sanford, Leonard L., Vernon County, Mar. 17, 1971
Waisman, Harry A., nonmember, Mar. 19, 1971
Matthews, G. C., Rock County, Mar. 22, 1971
Miller, Russell H., nonmember, Mar. 26, 1971
Dollard, James E., Dane County, Mar. 30, 1971
Frechette, Francis M., Rock County, Apr. 4, 1971
Doege, Karl H., Wood County, Apr. 12, 1971 □

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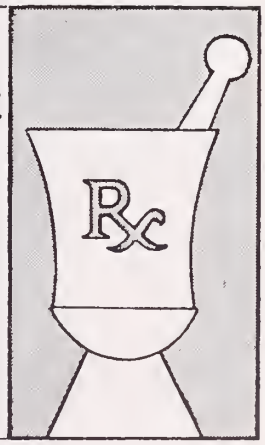

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This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Aug. 5–28: Scandinavian/Russian Holiday, Wisconsin Alumni Association. Info: Wisconsin Alumni Tours, 650 N. Lake St., Madison, Wis. 53706.

Aug. 25–28: *Emergency Care and Transportation of the Sick and Injured,* Wisconsin Center, Madison. Chrm. K. M. Sachtjen, MD, 2704 Marshall Court, Madison 53705. Sponsored by American Academy of Orthopaedic Surgeons. Info: American Academy of Orthopaedic Surgeons, 430 North Michigan Ave., Chicago, Ill. 60611.

Sept. 10–11: Annual scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel and Tower, Milwaukee.

Sept. 22: Sixth annual Adolf Gundersen Symposium for Physicians—"Understanding Arrhythmias." Co-sponsored by the Wisconsin Heart Association and the Adolf Gundersen Foundation. Valhalla Hall, Wisconsin State University, La Crosse.

Sept. 30–Oct. 2: District VI Meeting of American College of Obstetricians and Gynecologists and Nurses Conferences, Loraine Hotel & Park Motor Inn, Madison.

Oct. 16: Seventeenth Annual Fall Cancer Conference (scrimmage), Division of Clinical Oncology, University of Wisconsin Medical Center, Madison and Wis. Division of American Cancer Society. Info: Robert J. Samp, MD, University Hospitals, Madison, Wis. 53706.

Oct. 17–23: Wisconsin Work Week of Health.

1971 NEIGHBORING STATES

Sept. 13.–15: *Clinical Electroencephalography.* American Electroencelphalographic Society, in Minneapolis, Minn. Info: Donald W. Klass, MD, EEG Course Dir., Mayo Clinic, Rochester, Minn. 55901.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Oct. 4–9: Postgraduate course in Laryngology and Broncho esophagology, Department of Otolaryngology of the University of Illinois at the Medical Center, University of Illinois Eye and Ear Infirmary, Chicago, Ill.

Oct. 10: Joint scientific meeting, American College of Preventive Medicine and Association of Teachers of Preventive Medicine, Hotel Leamington, Minneapolis, Minn.

Oct. 23–29: Annual Otolaryngologic Assembly of 1971, University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

1971 OTHERS

July 5–8: *Ophthalmology.* University of Colorado School of Medicine, Colorado Springs.

July 11–14: *Pediatrics.* University of Colorado School of Medicine, Aspen.

July 11–22: *Summer Program in Human Sexuality.* Lecture courses with special reference to the medical aspects of human sexuality, workshops in sex education and counseling, small group discussions. $325, includes housing. Registration ends May 30. Write: Summer Program, Institute for Sex Research, Indiana University, Bloomington, Ind. 47401.

July 12–14: *Chronic Diseases of Childhood,* American Academy of Pediatrics, Stanford University School of Medicine and Children's Hospital at Stanford, Palo Alto, Ca. Info: Gerald E. Hughes, MD, Director, Dept. of Educational Affairs, American Academy of Pediatrics, P. O. Box 1034, Evanston, Ill. 60204.

July 16–18: *Effective Medical Communication* Seminar, UCLA Extension, University of California's Residential Conference Center, Lake Arrowhead, Calif. Info: Donald Brayton, MD, Director, Department of Continuing Education in the Health Sciences, Room 15–39, Rehabilitation Center, University Extension, UCLA, Los Angeles, Ca. 90024, or tel. Mrs. Elizabeth Gifford at (213) 825–7186.

July 20–24: *Internal Medicine.* University of Colorado School of Medicine, Estes Park.

July 22–23: Second annual *Seminar in General Surgery,* Colby College, Waterville, Maine. Info: Paul D. Walker, Jr., Director of Special Programs, Colby College, Waterville, Maine 04901.

July 26–29: *Recent Advances in Rheumatic Diseases.* American College of Physicians and University of Colorado School of Medicine, Estes Park.

July 29–31: *Chronic Inflammatory Diseases of the Gut,* American Gastroenterological Association, Aspen, Colo. Info: Mrs. Bernie C. Kern, 740 Krameria St., Denver, Colo. 80220.

Sept. 27–Oct. 1: *Hospital Medical Staff Conference,* University of Colorado School of Medicine, Estes Park.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Oct. 5–7: *18th Spinal Cord Injury Conference.* Joint meeting of Veterans Administration Department of Medicine and Surgery and International Medical Society of Paraplegia, Children's Hospital Medical Center, Boston, Mass.

Oct. 20–22: 18th Western Cardiac Conference, University of Colorado Medical Center, Denison Auditorium, Denver. Info: Colorado Heart Assn., 1375 Delaware St., Denver, Colo. 80204.

Nov. 8–12: Course in *Occupational Health for Nurses,* Department of Environmental Medicine of New York University School of Medicine in cooperation with American Association of Industrial Nurses. Tuition: $175. Course No. 484. Applications to: Office of Recorder, N. Y. U. Post-Grad. Medical School, 550 First Avenue, New York, N. Y. 10016.

Nov. 9–10: Annual Scientific Meeting, Council on Arteriosclerosis of the American Heart Association, Anaheim, Calif.

Nov. 11–14: 44th Annual Scientific Sessions, American Heart Association, Convention Center, Anaheim, Calif.

Nov. 15–18: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, 307 No. Charter St., Madison, Wis. 53715)

Nov. 17–19: Annual Conference, National Society for the Prevention of Blindness, Inc., The Roosevelt Hotel, New York City. (Papers, panel discussion and seminars on the latest developments in detecting and combating potentially blinding eye disease, community-action eye health programs, and programs for industrial and school safety.)

1971 AMA

Aug. 29–30: 31st Annual AMA Congress on Occupational Health, Jackson Lake Lodge, Grand Teton National Park, Wyoming. Info: Louis R. Skiera, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

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Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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1972 WISCONSIN

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Apr. 23–29: Ninth Interamerican Congress of Cardiology, San Francisco, Calif.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Biltmore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New York N.Y. 10017.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

For listing of other meetings see the **Journal of the American Medical Association.**

Chest Physicians Annual Scientific Session

The American College of Chest Physicians (ACCP) will hold its Third Annual Fall Scientific Assembly (37th Annual Meeting) in Philadelphia, Pa., Oct. 24–28. All sessions will take place at the Sheraton Hotel.

The 1971 meeting will have as its theme "Respiratory and Cardiovascular Care, The Clinician's Challenge."

Among scientific highlights will be nine major symposiums on specific problem areas in cardiovascular and pulmonary medicine; special teaching sessions at which outstanding clinician-teachers will demonstrate techniques in diagnosis and answer questions on electrographic and x-ray

problems; a full day of clinic teaching sessions at Philadelphia-area hospitals; special television clinics, and scientific and technical exhibits.

A copy of the advance program and information on hotel reservations and registration may be obtained from Alfred Soffer, MD, Executive Director, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611.

Annual Cancer Conference (Scrimmage)—Madison

The 17th annual cancer conference (scrimmage) will be held Saturday, October 16, from 9 a.m. to 12 noon, followed by a luncheon.

Participants will have the opportunity to attend the football game between Michigan and Wisconsin in the afternoon.

The event is sponsored by the Division of Clinical Oncology, University of Wisconsin Medical Center, and the Wisconsin Division of the American Cancer Society.

Application can be made to Robert J. Samp, MD, University Hospitals, 1300 University Ave., Madison, Wis. 53706.

All state physicians will be receiving a preliminary program prior to the conference.

Congress on Occupational Health—Wyoming

The 31st Annual AMA Congress on Occupational Health will be held at Jackson Lake Lodge in Grand Teton National Park, Wyoming, August 29–30.

There is no registration fee. Hotel reservations to be made directly with the lodge. Congress program is acceptable for 12½ elective hours by the AAGP.

Wyoming State Medical Society will hold its annual meeting at the same lodge August 31–September 4.

A Wisconsin physician, Richard D. Stewart, MD, will be a guest lecturer at 3:45 p.m. Sunday, August 29, on the subject, "Carbon Monoxide—Behavioral Effects." He is professor and chairman of the Department of Environmental Medicine, Medical College of Wisconsin, Milwaukee.

Emergency Care Course—Madison

The Committee on Injuries of the American Academy of Orthopaedic Surgeons will be conducting a series of courses on Emergency Care during 1971, including one in Madison on August 25–28. The Madison course chairman is Kenneth M. Sachtjen, MD.

Tuition: $50. All courses are designed to bring the latest practical concepts and techniques concerning emergency care and transportation of the sick and injured to those with such responsibilities. All registrants are expected to have had advanced first aid training.

Courses are designed for ambulance, civil defense, industrial safety, and public health personnel; emergency medical technicians, emergency squads, volunteer rescue squads, firemen, policemen, safety engineers, and nurses.

Info: AAOS. 430 North Michigan Ave., Chicago, Ill. 60611; tel. 312/822-0970.

Western Cardiac Conference—Denver

The Colorado Heart Association in cooperation with the University of Colorado Medical Center will sponsor the 18th Western Cardiac Conference October 20–22 in Denver.

"What's New in Cardiology" is the theme of the meeting which will be held in Denison Auditorium at the Medical Center.

Guest faculty includes: Dean T. Mason, MD, University of California–Davis; Henry Marriott, MD, St. Anthony's Hospital, St. Petersburg, Fla.; Harvey Fiegenbaum, MD, Indiana University Medical Center; W. Sterling Edwards, MD, University of New Mexico School of Medicine; Eoin Aberdeen, MD, Children's Hospital, Philadelphia; James J. Nora, MD, University of Colorado Medical Center; and other local participants.

Fee: $35 for out-of-state participants. Info: Colorado Heart Association, 1375 Delaware St., Denver, Colo. 80204.

Chronic Diseases of Childhood—California

The American Academy of Pediatrics will present a postgraduate course on chronic diseases of childhood, July 12–14, at Stanford University School of Medicine and Children's Hospital at Stanford, Palo Alto, California.

The aims of this course are to review recent advances in the diagnosis and treatment of chronic diseases of childhood and to discuss improved techniques for the delivery of health services to children with chronic handicapping conditions.

An attempt will be made to present material pertinent to the everyday practice of pediatrics. Round table discussions will offer ample opportunity for an exchange of questions and ideas between registrants and faculty.

Specific clinical topics will be covered by subspecialists in hematology, allergy, rheumatology, clinical immunology, chest diseases and anesthesiology. Other clinical topics to be discussed include: psychiatry, genetics, renology, radiology, endocrinology and gastroenterology.

Guidance will be offered in recognizing and dealing with symptoms associated with the emotional impact of chronic diseases on children and their families. New child-centered treatment facilities and practices developed at the Children's Hospital will be reviewed and criticized. Measures to improve coordination of activities concerning chronically diseased children between hospitals and community health agencies will be discussed. Programs will also be outlined for the social rehabilitation of chronically ill and disabled children.

Course chairman is Robert J. Schlegel, MD, FAAP, associate professor of pediatrics, Stanford University School of Medicine.

Info: Gerald E. Hughes, MD, FAAP, director, Department of Educational Affairs, American Academy of Pediatrics, P. O. Box 1034, Evanston, Ill. 60204.

Annual Otolaryngologic Assembly

The Annual Otolaryngologic Assembly of 1971 will be held October 23 through 29 in the University of Illinois Hospital Eye and Ear Infirmary. The Department of Otolaryngology, Abraham Lincoln School of Medicine, University of Illinois at the Medical Center, offers a condensed postgraduate basic and clinical program for practicing otolaryngologists under the direction of Emanuel M. Skolnik, MD. It is designed to bring to specialists current information in medical and surgical otorhinolaryngology.

Interested otolaryngologists should direct their inquiries to Otolaryngology, P.O. Box 6998, Chicago, Ill. 60680.

A separate, but correlated course, "Conference on Radiology in Otolaryngology and Ophthalmology," will be held this year on Friday and Saturday, November 26 and 27, under the guidance of Galdino E. Valvassori, MD.

For further information write to Professor Valvassori, Radiology Conference, Abraham Lincoln School of Medicine, P.O. Box 6998, Chicago, Ill. 60680. □

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Proloid (thyroglobulin) is stable when stored at usual room temperature.

Indications: Proloid (thyroglobulin) is thyroid replacement therapy for conditions of inadequate endogenous thyroid production: e.g., cretinism and myxedema. Replacement therapy will be effective only in manifestations of hypothyroidism.

In simple (nontoxic) goiter, Proloid (thyroglobulin) may be tried therapeutically, in nonemergency situations, in an attempt to reduce the size of such goiters.

Contraindication: Thyroid preparations are contraindicated in the presence of uncorrected adrenal insufficiency.

Warnings: Thyroglobulin should not be used in the presence of cardiovascular disease unless thyroid-replacement therapy is clearly indicated. If the latter exists, low doses should be instituted beginning at 0.5 to 1.0 grain (32 to 64 mg) and increased by the same amount in increments at two-week intervals. This demands careful clinical judgment.

Morphologic hypogonadism and nephroses should be ruled out before the drug is administered. If hypopituitarism is present, the adrenal deficiency must be corrected prior to starting the drug.

Myxedematous patients are very sensitive to thyroid, and dosage should be started at a very low level and increased gradually.

Precaution: As with all thyroid preparations this drug will alter results of thyroid function tests.

Adverse Reactions: Overdosage or too rapid increase in dosage may result in signs and symptoms of hyperthyroidism, such as menstrual irregularities, nervousness, cardiac arrhythmias, and angina pectoris.

Dosage and Administration: Optimal dosage is usually determined by the patient's clinical response. Confirmatory tests include BMR, T_3 ^{131}I resin sponge uptake, T_3 ^{131}I red cell uptake, Thyro Binding Index (TBI), and Achilles Tendon Reflex Test. Clinical experience has shown that a normal PBI (3.5-8 mcg/100 ml) will be obtained in patients made clinically euthyroid when the content of T_4 and T_3 is adequate. Dosage should be started in small amounts and increased gradually with increments at intervals of one to two weeks. Usual maintenance dose is 0.5 to 3.0 grains (32 to 190 mg) daily.

Instructions for Use: The following conversion table lists the approximate equivalents of other thyroid preparations to Proloid (thyroglobulin) when changing medication from desiccated thyroid, T_4 (sodium levothyroxine), T_3 (sodium liothyronine), or T_4/T_3 (liotrix).

Dose of Proloid (thyroglobulin)	Dose of desiccated thyroid	Dose of T_4 (sodium levothyroxine)	Dose of T_3 (sodium liothyronine)	Dose of liotrix (T_4/T_3)
1 grain	1 grain	0.1 mg	25 mcg	#1 (60 mcg/15 mcg)
2 grains	2 grains	0.2 mg	50 mcg	#2 (120 mcg/30 mcg)
3 grains	3 grains	0.3 mg	75 mcg	#3 (180 mcg/45 mcg)
4 grains	4 grains	0.4 mg	100 mcg	
5 grains	5 grains	0.5 mg	125 mcg	

In changing from Thyroid USP to Proloid (thyroglobulin), substitute the equivalent dose of Proloid (thyroglobulin). Each patient may still require fine adjustment of dosage because the equivalents are only estimates.

Overdosage Symptoms: Headache, instability, nervousness, sweating, tachycardia, with unusual bowel motility. Angina pectoris or congestive heart failure may be induced or aggravated. Shock may develop. Massive overdosage may result in symptoms resembling thyroid storm. Chronic excessive dosage will produce the signs and symptoms of hyperthyroidism.

(Treatment: In shock, supportive measures should be utilized. Treatment of unrecognized adrenal insufficiency should be considered.)

How Supplied: ¼ grain; ½ grain; scored 1 grain; 1½ grain; 3 grain; and scored 5 grain tablets, in bottles of 100 & 1000; and scored 2 grain tablets in bottles of 100.

Warner-Chilcott, Morris Plains, N. J. 07950

BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262-6594.

BOOKS RECEIVED

ALZHEIMER'S DISEASE

Edited by G. E. W. Wolstenholme & Maeve O'Connor. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1970. 316 pages

TASTE AND SMELL IN VERTEBRATES

Edited by G. E. W. Wolstenholme and Julie Knight. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1970. 402 pages

SENSORINEURAL HEARING LOSS

Edited by G. E. W. Wolstenholme and Julie Knight. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1970. 358 pages

THE LOW FAT LOW CHOLESTEROL DIET

By Clara-Beth Young Bond, E. Virginia Dobbin, Helen F. Gorman, MD, Helen C. Jones, Lenore Lyon. Doubleday & Company, Inc., Garden City, N. Y. 1971. 512 pages. Price: $7.95

BOOK REVIEWS

CURRENT PRACTICE IN ORTHOPAEDIC SURGERY

Vol. 4, by John P. Adams, BS, MD, FACS, Editor. The C. V. Mosby Co., Saint Louis, Mo. 1969. 286 pages. Price: $22.50

I must say there has been a definite need for this type of effort and this is a very commendable goal. However, this is a very difficult goal to reach.

The editor has in all volumes been fortunate enough to gather together highly esteemed authors in their respective fields. Orthopedic surgeons, developing residents, and academic orthopedic surgeons find these volumes of very practical importance. I am not sure that the authors have covered the field entirely in all instances but certainly they have covered their own ideas about the particular subject well, and the reader will have no question in his mind about how the writer handles the problem.

The fourth volume consists of historical sketches by Alfred R. Shands, Jr. on three pioneer American orthopedic surgeons which any orthopedic surgeon and particularly a developing resident should enjoy reading. The other eight articles cover a wide range in the field of orthopedics and present a tremendous amount of information. Not all of these have exhausted the subject nor do they carry a review of the recent developments. A survey of a wider bibliography seems indicated. All of the preceding volumes including Volume 4 are well illustrated, read easily, and the index is exceptionally good.

The editor is making a valiant effort to achieve the good he has started out to achieve and I am sure the future volumes will all show improvement.—HERMAN W. WIRKA, MD

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WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Report on 1971 House of Delegates Session; Dr. Behnke Installed; Dr. Purtell Elected

Dr. George A. Behnke of Kaukauna was installed as the 113th president of the State Medical Society of Wisconsin at the third session of the House of Delegates which met May 9–11 in Milwaukee during the Annual Meeting of the Society.

Elected to the post of president-elect was Dr. Robert F. Purtell, Sr. of Milwaukee. Dr. Purtell will become president next May.

Dr. Behnke has been practicing family medicine in Kaukauna since 1946 when he returned from military service. He is a 1942 graduate of the University of Wisconsin Medical School.

He served as president of the Outagamie County Medical Society in 1958–59. He was elected vice-speaker of the SMS House of Delegates in 1964 until 1967 when he became speaker. He remained speaker until 1970 when he was elected president-elect.

He is active in the Wisconsin Academy of General Practice and is health officer for the city of Kaukauna.

Dr. Purtell

Dr. Behnke

Dr. Purtell, also a general practitioner, has spent his entire life in and around the Milwaukee area.

He was born Aug. 4, 1908, in Monches (Waukesha County), graduated from Marquette University School of Medicine in 1930, and completed his internship and residency training at Milwaukee County General Hospital.

Dr. Purtell served as president of the Medical Society of Milwaukee County in 1965; he also has held offices in the Wisconsin Academy of General Practice and Milwaukee Academy of Medicine.

He served for 10 years on the State Medical Society's Maternal and Child Welfare committee, and was its chairman for three years.

Dr. Purtell has served as Milwaukee county's delegate to the state society since the 1940's.

Health Care Review Organization Given Go Ahead

The State Medical Society's Council authorized the establishment of a separate health care review organization, or "foundation," at its May 8 meeting in Milwaukee.

The action was subsequently endorsed by the Society's House of Delegates at its sessions May 9–11 during the Annual Meeting of the Society.

Believing that it is both timely and feasible for establishment of such an organization, the Society has placed top priority toward its implementation.

As set forth by the Council, the organization's purposes would be "to handle peer review, utilization review and other submitted matters involving health care contracts which are in addition to those between patients, physicians, other providers and health institutions . . . together with such other functions as may be determined to be essential or advisable."

The Council outlined the following guidelines for implementation of the new review organization:

1. A nonstock, nonprofit corporation to be organized separately from the Society's structure.
2. Financing to be arranged by the Council through its Finance and Executive committees who will have authority to act.
3. Consist of a board which could include one or more representatives of each professional or other body whose claims it would review.
4. Have its own staff and facilities, including a director whose background would qualify him for conducting an effective peer review program.
5. Permit the review of claims of physicians, other providers, health institutions, and insurance carriers.
6. Reviews to be conducted by persons with the background and discipline involved in the matter under consideration; i.e., the review of physicians' services would be

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IN NATIONAL HEALTH CARE

President Behnke Urges Free Enterprise System

Addressing the State Medical Society's House of Delegates at its opening session May 9, the incoming president, Dr. George A. Behnke of Kaukauna, urged physicians to support a national health insurance plan that would provide free choice of physicians, preserve the doctor–patient relationship, and above all, maintain the free enterprise system practice of medicine.

Dr. Behnke also touched upon the greatest concern and need in Wisconsin — increasing medical manpower.

"We need to continue to exert friendly persuasion upon medical schools to increase their enrollment, to change their emphasis from research to the projection of clinical physicians, particularly of the primary practice type," he declared.

The new president expressed satisfaction in having a better rapport between the state legislature and the state medical society. He emphasized the cooperation between the two on suggested methods of increasing health manpower.

The full text of his message appears elsewhere in this issue.

Presidential Appointments

The new president, Dr. George A. Behnke of Kaukauna, appointed 24 state physicians to six society committees as one of his initial acts in office.

Those appointments are as follows:

Committee on Cancer: Drs. G. A. Smiley, Delavan, R. C. Frank, Eau Claire, G. I. Uhrich, La Crosse, and J. F. Brown, Rhinelander, reappointed; and Drs. J. D. Hurley, Milwaukee, and J. J. Tydrich, Richland Center. Dr. John K. Scott of Madison was named chairman.

Committee on Grievances: Dr. E. W. Mason, Milwaukee, reappointed; and Drs. H. J. Dick, Sheboygan, and Walther W. Meyer, Medford. Dr. Mason also was renamed chairman.

Commission on Public Policy: Drs. W. T. Russell, Sun Prairie, Wayne Boulanger, Milwaukee, reappointed; and Drs. J. H. Wishart, Eau Claire; G. S. Woodward, Milwaukee; G. L. Lucas, Madison; G. L. Apfelbach, Jr., Janesville; and DeLore Williams, Milwaukee. Dr. Russell was reappointed chairman.

Commission on Health Information: Drs. R. G. Hansel, Baraboo, and W. C. Harris, Racine, reappointed; and Drs. Louis Olsman, Kenosha, and A. G. Brailey, Jr., La Crosse. Dr. Hansel was appointed chairman.

Commission on Hospital Relations and Medical Education: Drs. D. R. Korst, Madison; M. G. Parker, Racine; and J. A. Killins, Green Bay. Dr. D. V. Moen of Shell Lake was reappointed chairman.

Commission on Scientific Medicine: Drs. Edward Zupanc of Monroe, L. G. Crocker of Madison, and S. A. Graziano of Milwaukee. This committee selects its own chairman.

Attendance: 2,129

Total attendance of the three-day scientific program, May 10–12, was 2,129.

Registration of physician members was 1,212, while the balance consisted of 44 physician guests, 172 interns–residents–medical students, 341 exhibit representatives, and 360 guests (certified nurses, physicians' wives, etc.).

The three sessions of the House of Delegates had the following registrations: 101, first session; 123, second session; and 91, third session. There are 137 voting members of the House.

Election Results

The House of Delegates elected the following physicians to positions where terms were expiring or vacated:

PRESIDENT-ELECT: Dr. Robert F. Purtell, Milwaukee.

SPEAKER: Dr. T. J. Nereim, Mount Horeb, two years.

VICE-SPEAKER: Dr. W. D. Hamlin, Mineral Point.

COUNCILORS: Drs. M. F. Huth, Baraboo; J. E. Dettmann, Green Bay; E. P. Rohde, Galesville (reelected); and Drs. R. D. Heinen, Oconto Falls; R. F. Lewis, Marshfield; DeLore Williams, West Allis; R. B. Pittelkow, Milwaukee; and W. W. Meyer, Medford.

DELEGATES TO AMA: Drs. W. B. Hildebrand, Menasha; and R. E. Galasinski, Milwaukee (reelected).

ALTERNATE DELEGATES TO AMA: Drs. W. T. Russell, Sun Prairie; and H. F. Twelmeyer, Wauwatosa (reelected).

The Council elected physicians to the following positions:

CHAIRMAN OF THE COUNCIL: Dr. E. J. Nordby, Madison (reelected).

VICE-CHAIRMAN: Dr. J. E. Dettmann, Green Bay.

TREASURER OF THE SOCIETY: Dr. F. L. Weston, Madison (reelected).

ASSISTANT TREASURERS serving the Society, SMS Realty Corporation, and Wisconsin Physicians Service: Drs. H. Kent Tenney, N. A. Hill, J. T. Sprague, and R. A. Sievert, all of Madison (reelected), and A. A. Quisling, Madison.

EDITORIAL DIRECTOR of the *Wisconsin Medical Journal:* Dr. Raymond Headlee, Elm Grove.

HEALTH CARE REVIEW

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made by physicians; the review of dental services by a committee of dentists; the review of a hospital claim by a committee of hospital administrators.

Final approval of organizational plans will be by the Council.

In other matters, the Council adopted a policy statement concerning alternative methods of organizing and financing health care.

The statement called for the State Medical Society, as in the past, to inspire, participate in, and provide leadership for new ways to improve the delivery of quality medical care at reasonable cost for all the people of Wisconsin.

This includes affirmative response to professional and nonmedical groups seeking the help of the Society and its WPS–Blue Shield program in the development of prepaid group programs, cooperative plans, or other mechanisms for improving the financing and delivery of health services.

In view of the above, the Council reported that it was studying the health maintenance organization (HMO) concept.

An HMO has been described by the Health, Education, and Welfare (HEW) Department as "an organization which operates or manages an organized health services delivery system on a prepaid capitation basis for enrolled population groups, designed to provide comprehensive health care economically and effectively."

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MANAGING EDITOR: Earl R. Thoyer, Secretary, State Medical Society of Wisconsin.

THIS ISSUE of the Green Sheet replaces the formal printing of Reports and Proceedings of the Annual Session of the House of Delegates, May 9–11, 1971, due to the great expense involved. Members of the Society may, upon request, study the Official Transcript of the meeting at the State Medical Society Headquarters in Madison.

The House deliberated 39 resolutions as well as reports of officers, the Council, committees and commissions of the Society. Following is a summary of actions taken on recommendations of the four reference committees:

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

● PRESIDENT'S REPORT—The House commended President Jerry W. McRoberts for an excellent year in his term of office and concurred in his belief that "it was a good year."

● PRESIDENT-ELECT'S REPORT—Accepted the report of President-elect George A. Behnke, which appears elsewhere in the June issue in its entirety, with highlights on the GREEN SHEET cover page.

● SECRETARY'S REPORT—Accepted the report of Secretary Earl R. Thayer with commendation for taking hold of his responsibilities, and concurrence in the need for periodic revision of staff organization and definition of job responsibilities.

● COMMITTEE ON MILITARY MEDICAL SERVICE—Accepted the report of this committee with appreciation.

● COMMITTEE ON MEDICINE AND RELIGION—Accepted this committee's report with appreciation.

● COMMITTEE ON DISASTER MEDICAL CARE—Expressed sympathy with the wish of this committee to be disbanded by the Council, and suggested that the Council seek to assure the development of programs for well-trained and *certified* emergency medical technicians and facilities to provide emergency medical care and deal with natural or military disaster.

● COMMISSION ON STATE DEPARTMENTS—The House took the following actions on reports of its ten divisions:

Aging: Expressed the hope that the 1970 program on problems of the nursing home patient can be repeated during the 1971 Work Week of Health if at all possible.

Alcoholism and Addiction: Endorsed its report and urged the Commission on Medical Care Plans to give consideration to the means available for insurance coverage in institutions accredited for the treatment of alcoholism.

Chest Diseases; Ear, Nose and Throat; Handicapped Children; Nervous and Mental Diseases: Accepted the reports of these divisions with appreciation.

Maternal and Child Welfare: Commended its activities and particularly those of its subcommittee on maternal mortality; urged that members of the division consider attending a forthcoming national conference on maternal and neonatal health at which guidelines hopefully will be established for realistic statistical reporting in preparation for an international meeting to standardize such reporting.

Rehabilitation: Expressed agreement with its report and adopted a resolution contained therein on improving the employment status of the cardiac worker.

School Health: Accepted its report and particularly its desire to review the need to develop appropriate standards for health examinations given to girls participating in athletics; suggested that such physical examination be comparable to that given to boys and that both should be more comprehensive.

● COMMISSION ON HEALTH AND NATURAL RESOURCES: Expressed wholehearted agreement in accepting its report, recognizing that physicians are in the front line on identification of environmental problems that affect patients and should become more involved, more concerned, and more active in the reporting of pollution problems and in finding their solutions.

● ELECTION OF AMA DELEGATES—Rejected Resolution H (introduced by La Crosse County Medical Society) requesting election of AMA delegates by the membership, noting that the chief reason for its submission appeared to be lack of communication of national matters to the county level, and urging that the AMA delegates be invited to county medical society meetings on a periodic basis to provide information of national concern to the membership throughout the state. Also, in this way views and opinions of the local medical societies can receive visibility and upward mobility.

● CHARLES H. CROWNHART—Adopted Resolution R (introduced by Medical Society of Milwaukee County) commending Mr. Crownhart for his service to medicine; and further noted with full agreement and pleasure the special tribute afforded by the Council through its award.

● OPHTHALMIA NEONATORUM—Resolution Z (introduced by Door–Kewaunee County Medical Society) requesting study and reevaluation of silver nitrate in the prophylaxis of ophthalmia neonatorum, was rejected inasmuch as this practice may be more justified currently because of the unusual increase in venereal disease and increasing appearance of resistant strains of organisms.

● EMERGENCY HEALTH PERSONNEL ACT OF 1970—Adopted Resolution II forwarded by the Council at the request of the Wisconsin Chapter of SAMA, asking the Council to study the advisability of implementing this Act.

● PRESCHOOL EYE AND EAR TESTING—Amended and adopted Resolution JJ (submitted by the Coun-

cil for Barron–Washburn–Sawyer–Burnett County Medical Society) as follows:

"*Resolved,* That the State Medical Society of Wisconsin encourage the Woman's Auxiliary to the State Medical Society to pursue the development of programs for preschool eye and ear testing in those areas in which no similar programs now exist; and to cooperate with, support, and assist in those programs currently providing such services."

● MEDICREDIT—Endorsed Resolution MM (submitted by the Council at the request of Councilor Schmidt) and requested that the Wisconsin congressional representatives be advised of the Society's endorsement of the proposal generally known as Medicredit, the "Health Care Insurance Assistance Act of 1971."

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES

● COMMISSION ON SCIENTIFIC MEDICINE—Accepted the Commission's report and recommended that the specialty societies which did not participate in the 1971 annual meeting and all other specialty societies be strongly urged to participate in the future to assure continuity and strengthen the House of Medicine as an entirety. In addition, the difficulties being encountered in obtaining technical exhibitors for the meeting were noted and the Commission requested to continue to seek alternate means of financing and format.

● COMMISSION ON HOSPITAL RELATIONS AND MEDICAL EDUCATION—Accepted the report of this Commission and recommended, in light of presentations made to the House by the two medical school Deans, that the Society immediately request the Joint Finance Committee of the Legislature to actively support adequate financial assistance to medical education in order to guarantee that the schools' (Medical College of Wisconsin and University of Wisconsin Medical School) programs will not deteriorate while waiting for countless studies to be conducted; further recommended that the Society's support should be based on the schools beginning immediately to take all necessary steps to assure that appropriate departmental status is granted to Family Medicine and that the preceptorship program be a part of the fourth year in both medical schools. In addition, the House recommended that the Deans be asked to report to the Commission on Hospital Relations and Medical Education during the course of the coming year and to the House next year on progress made in complying with this request.

● PHYSICIANS ON HOSPITAL GOVERNING BOARDS—Adopted the following substitute for Resolution S (introduced by the Medical Society of Milwaukee County), and recommended that where legally permissible, physicians shall be included in the membership of hospital governing boards:

"*Resolved,* That the governing board of every private and voluntary hospital in the State of Wisconsin give prompt and serious consideration to inclusion of physicians as members of the governing board with voting privilege and all other rights and responsibilities belonging to other board members; and be it further

"*Resolved,* That physicians appointed to the governing board be selected from the hospital medical staff or community at large, with preference given the medical staff members; and be it further

"*Resolved,* That, at the time of the next hospital survey by the Joint Commission on Accreditation of Hospitals, the executive committee of each hospital medical staff will reaffirm the desire of the staff to have physicians appointed to the governing board; and be it further

"*Resolved,* That the state and county medical societies establish standing committees to assist in the search for competent and capable physician candidates for board appointments when such assistance is requested; and be it finally

"*Resolved,* That a copy of this resolution be dispatched to the president of the governing board, the chief of the medical staff, and the administrator of each private and voluntary hospital in the State of Wisconsin."

● COMMISSION ON HEALTH INFORMATION—Accepted the Commission's report and recommendations concerning the need to increase public information efforts, and concurred with the suggestion that the Society create a "medical action line" as an aid to supplying information and responding to news published by the various media. In addition, the House requested investigation of the feasibility of the Society establishing a "Hot Line" telephone information program for physicians as has been so excellently done by the Medical Society of Milwaukee County.

● COMMITTEE ON OCCUPATIONAL HEALTH—Accepted its report and recommended that the committee reestablish its practice of working with various state agencies dealing with occupational health laws while maintaining liaison with the divisions of the Commission on State Departments which are assigned the primary advisory role in special interest areas such as vision, hearing, etc.

● COMMITTEE ON CANCER—Encouraged Society members to assist the committee in efforts to implement the cancer review and emendation program known as "CARE" in hospitals throughout the state.

● COMMISSION ON SAFE TRANSPORTATION—Accepted the Commission's report with commendation for its measurable accomplishments, its continuing attempt to develop forms for use by physicians when communicating with the Motor Vehicle Division, and its support of legislation which would develop a 0.10 level for alcohol impairment of driving ability, the need to officially create a medical advisory

board to the Division of Motor Vehicles, and special licensure of individuals driving school busses.

● School bus safety—Adopted Resolution M (introduced by the Sheboygan County Medical Society) urging legislation to mandate the installation and usage of passenger restraining systems on school busses; recommended that more adequate standards in other areas of school bus safety be developed by the Commission on Safe Transportation working with the State Department of Public Instruction.

● Standards for ambulance attendants and equipment—The House noted that the Society has previously gone on record in support of legislation calling for the development of an official program to establish and maintain minimum standards for ambulance attendants and equipment. It adopted Resolution Y (introduced by the Medical Society of Milwaukee County) supporting Assembly Bill 367 on this subject, with the qualification that the Commissions on Safe Transportation and Public Policy be authorized to seek amendments which will assure that standards are not developed that will in effect leave certain areas of the state without any emergency transportation whatsoever.

● Commission on public policy—The House accepted the report and supplementary report of this Commission, with special note of two subjects:

Generic prescribing: Gave special support to the Commission's opposition of legislation which would make it mandatory that all prescriptions be on a generic basis.

Chiropractic: Called for special attention to the Commission's report that the cult of chiropractic is making every effort to extend practice privileges at the expense of the public's health; also adopted Resolution HH (forwarded by the Council at request of Councilor Chojnacki) that "the State Medical Society of Wisconsin shall vigorously seek to introduce legislation to remove the sanction of state licensure from the practice of chiropractic and to eliminate the cult of chiropractic from the State of Wisconsin."

● Contraceptives—Rejected Resolution FF (forwarded by the Council at request of Councilor Chojnacki) which called for support of Senate Bill No. 2 which would remove contraceptives from the list of indecent articles and enable dispensing by a physician or pharmacist to those over eighteen; reaffirmed the previously adopted position that the Society support legislation which would allow physicians to provide contraceptive measures and family planning information to all patients consistent with good medical practice.

● Venereal disease—Adopted Resolution F (introduced by the Richland County Medical Society) reaffirming the position already adopted by the Commission on Public Policy favoring legislation which would allow the treatment of venereal disease cases in a minor without parental consent.

● Certificate of need legislation—Adopted Resolution X (introduced by the Medical Society of Milwaukee County) opposing "Certificate of Need" legislation as not in the best interest of patient care; recommended that all physicians actively participate in comprehensive health planning.

● Nursing—Adopted Resolution G (introduced by the Richland County Medical Society) and Resolution J (introduced by the Clark County Medical Society) with the provision, as to the former, that the Society supports the implementation of both two and three year nursing schools as well as legislation which would modify existing laws so as to facilitate the recruitment and employment of well qualified out-of-state nurses.

● Charitable, educational and scientific foundation—The reference committee enlisted the aid of the House in calling upon all members to support activities of the Foundation which are of such great importance to the Society.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS

● Bylaw amendments—The House approved the recommendation of the Council that Chapter X of the Bylaws be amended to change the basic parliamentary authority from Roberts' Rules of Order to the Sturgis Standard Code of Parliamentary Procedure.

Adopted Resolution P (Medical Society of Milwaukee County) amending Chapter XI, Section 3, of the Bylaws, by deleting the words "upon payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society . . ." having the effect of permitting county medical societies and the State Society each to establish the amount of dues for those in training as hospital residents or as research fellows.

● Section on plastic surgery—Approved a recommendation of the Council creating a Section on Plastic Surgery.

● Section delegate voting privileges—Requested appointment of a committee to reexamine the whole question of voting privileges for the section delegates and report back to the House next year.

● Professional liability—Approved recommendation of the reference committee that Resolutions A (Racine County Medical Society), C and BB (Waukesha County Medical Society), not be adopted in view of information received that the Council is actively considering questions relating to "group" professional liability insurance and review mechanisms. Adopted Resolution Q (Medical Society of Milwaukee County) on a motion from the floor, "That the House of Delegates instruct the Councilors and staff of our State Society to begin immediate and intensive negotiations with these (Argonaut and Travelers) and other companies in order to make group protection available to our membership;" and further, "That the Councilors submit to component county societies, six months from the

date of this Annual Meeting, a written report on the progress of these negotiations."

● ACHIEVEMENTS OF MEDICINE—Rejected Resolution D (Richland County Medical Society) suggesting public reaffirmation of the achievements of medicine, as its manner of presentation was not believed indicated in view of the positive direction the Society is taking in such areas as the position paper on health manpower, and as indicated in "The Summing Up" by President McRoberts in the April issue of the *Wisconsin Medical Journal.*

● AMA DUES—Rejected Resolution I (La Crosse County Medical Society) relative to the manner of voting for increases in AMA dues, on the basis of information from the AMA delegates on recent changes in AMA procedures which tend to take care of the objections expressed.

● DEFINITION OF DEATH—Rejected Resolution N (Medical Society of Milwaukee County) proposing a statutory definition, in the belief that the province of the determination of death should be retained as a matter for the art and science of the physician or physicians concerned.

● HEALTH MANPOWER—Adopted Resolution O (Medical Society of Milwaukee County) commending all those involved in development of the Society's position paper on health manpower, and urging the Legislature and medical schools to implement its recommendations.

● NATIONAL LICENSURE OF PHYSICIANS—Adopted Resolution T (Medical Society of Milwaukee County) opposing the concept of national licensure of physicians and favoring the maintenance of local control within the State Medical Examining Board.

● PHYSICIAN ASSISTANTS—Adopted Resolution W (Medical Society of Milwaukee County) commending all those involved in development of experimental legislation for the certification of physician assistants.

● COMPREHENSIVE HEALTH PLANNING—Rejected Resolution CC (Waukesha County Medical Society) proposing the establishment of regional medical liaison organizations geographically consistent with CHP organizations, on the basis that there is insufficient understanding at this time as to the direction of Comprehensive Health Planning.

● COLLEGE HEALTH—Adopted Resolution DD (Waukesha County Medical Society) encouraging utilization by all state colleges and universities, public and private, of a uniform physical examination form and immunization requirements, with referral to the Division on School Health for implementation.

● CONTINGENCY FEES—Rejected Resolution KK (submitted by the Council for Barron–Washburn–Sawyer–Burnett County Medical Society) relating to abolishment of contingency fees in malpractice suits, as untimely in view of pending legislation.

● ABORTION—Adopted Resolution U (Medical Society of Milwaukee County) "That no patient, physician, nurse, or allied health professional be required by law or other mandatory directive to submit to, participate in or assist in the performance of an abortion for whatever reason."

The reference committee reported as to Resolution GG (forwarded by the Council at the request of Councilor Chojnacki) that following careful review of the arguments pro and con in this area of deep interest, it concluded that no compelling reason had been offered for modifying the action taken by the House in 1970. (The resolution requested recission of the 1970 action "That the State Medical Society of Wisconsin support legislation which would clarify current court rulings on abortion, and clearly establish the right of a physician to abort an unquickened product of conception.") The reference committee felt fortified in its position by an opinion of the Judicial Council of the AMA relative to the relationship of medical ethics and abortion, which reads:

> "The Principles of Medical Ethics of the AMA do not prohibit a physician from performing an abortion that is performed in accordance with good medical practice and under circumstances that do not violate the laws of the community in which he practices.
>
> "In the matter of abortions, as of any other medical procedure, the Judicial Council becomes involved whenever there is alleged violation of the Principles of Medical Ethics as established by the House of Delegates."

The committee recommended that Resolution GG not be adopted for the additional reason that the continuing pendancy of both court appeals and legislation in this state made it inappropriate to interpose any further complications in the public law area, and meanwhile, the professional considerations appear to have been adequately safeguarded by the AMA statement.

The committee's motion that Resolution GG not be adopted lost by a vote of 60–62.

A subsequent motion from the floor that the resolution be adopted also lost by a vote of 51–62.

REFERENCE COMMITTEE ON FINANCES

● COMMISSION ON MEDICAL CARE PLANS—Accepted its report and complimented the leadership of the members of the Commission and the insurance director, Mr. Koenig, in administering a financially sound plan at a time when many other plans are experiencing fiscal difficulties; emphasized that WPS–Blue Shield is engaging in experimental plans for more comprehensive benefits while at the same time maintaining these good financial results; noted the extensive WPS advertising program that is effectively bringing the Society's prepaid health care plans to the attention of Wisconsin citizens.

● 1971 BUDGET, REPORT OF TREASURER, DUES FOR 1972—The House complimented the Council, its Finance Committee, and the staff for a realistic approach to maintaining expenditures at an appropriate level in relation to the current economic atmosphere, and the improved financial picture in the Society's general fund; encouraged the Council to continue efforts to provide the membership with an effective medical journal while at the same time

NOMINATING COMMITTEE—(Seated) Doctors J. G. Bergwall, Hortonville; L. O. Simenstad, Osceola; Robert Bein, Racine; C. J. Picard, Superior; and V. M. Griffin, Mauston. (Standing) Doctors P. G. LaBissoniere, Wauwatosa; J. E. Taxman, Milwaukee; C. E. Mueller, Bascobel; R. B. Larsen, Wausau; R. D. Heinen, Oconto Falls; W. W. Meyer, Wauwatosa; and Jordan Frank, Beloit. Other members not present for the picture: Doctors P. W. Wallestad, Port Washington, and C. E. Quandt, Jefferson.

seeking additional areas in which to reduce cost; noted that the members find the "Green Sheet" section especially valuable; complimented Treasurer Weston on his continuing efforts and attention to the financial affairs of the Society; continued dues at the present amount for 1972.

● HEALTH CARE REVIEW ORGANIZATION—Adopted the recommendations of the Council on development of a health care review organization which can have great significance to the people of Wisconsin, the medical profession, and other providers of health services; urged each delegate to bring this development to the attention of members of his county medical society.

● CODING AND NOMENCLATURE—In reference to Resolution B (Fond du Lac County Medical Society) urging adoption of the AMA system of coding and nomenclature, the House accepted the statement of the reference committee that most physicians desire a system of coding and nomenclature which will ease the clerical burden of reporting and describing professional services for purposes of third party payment; however, the technical decision as to whether this should be a four digit or five digit coding system is one which should be made in consideration of costs as well as uniformity of application. Wisconsin Physicians Service–Blue Shield and Surgical Care–Blue Shield were asked to give serious consideration to it, but with a view to protecting the best interests of the physician regardless of the cost.

● CODING, RELATIVE AND UNIT VALUES—Rejected Resolution E (Richland County Medical Society) in the belief that the particular proposals of the resolution with regard to periodic referenda are impractical, but supported the sentiment that the AMA expand its efforts to act as advocate for all physicians in opposing bureaucratic governmental health programs.

● MEDICARE FEES—Adopted Resolution K (Dane County Medical Society) calling on all members of the profession individually, and through their professional organizations, to resist by appropriate means the payments for professional services based on HEW policies which are inconsistent with the provisions of the Medicare law. It was noted that physicians have available the decision whether to accept assignments at all in Medicare cases. If a physician concludes to accept assignments, he should make it plain to his patients and to his Congressional representative that the gap between his reasonable charge and the payment allowed him is not of his making, but is the direct result of the disregard of the Medicare law by HEW.

● HEW REGULATIONS—Resolutions L and LL (Dane County Medical Society) concerned HEW regulations regarding frequency of physician visits and types of care reimbursable when provided patients in extended care facilities, skilled nursing homes and nursing homes. The House supported Resolution L in principle and adopted Resolution LL. Resolution EE (Waupaca County Medical Society) was not adopted in view of action on Resolution K and L.

● TREATMENT OF ALCOHOLISM—In reference to Resolution AA (Waukesha County Medical Society) the House supported the recommendation that all insurance plans provide this benefit, as well as the recommendation that all general hospitals develop alcoholic treatment programs, and accepted clarifying information that WPS does provide coverage for treatment of alcoholics in general hospitals where such hospitals do have an alcoholic treatment program.

THE FOLLOWING FINANCIAL STATEMENTS are a part of the Annual Certified Audits prepared by Donald E. Gill & Company, certified public accountants, and reflect the general financial condition of the Society at December 31, 1970. ■ Audit reports were prepared for the State Medical Society of Wisconsin and its related organizations: State Medical Society of Wisconsin (General Fund), Wisconsin Medical Journal, Wisconsin Physicians Service, Civilian Health and Medical Program of the Uniformed Services, Supplemental Medical Insurance Benefits for the Aged, SMS Realty Corporation, Charitable, Educational and Scientific Foundation, Inc., Student Loan Fund, Employees' Pension Plan and Trust Agreement, and WPS Charge Card Corporation. ■ These reports, in their entirety, may be reviewed by members upon request to the State Medical Society office.

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund

Madison, Wisconsin

BALANCE SHEET

December 31, 1970

ASSETS		
Current Assets		
Cash		$ 82,349.90
Accounts Receivable—General		6,137.55
Due from Employees		400.31
Due from Charitable, Educational, and Scientific Foundation Incorporated		8,623.68
Due from SMS Realty Corporation		2,906.66
Due from Wisconsin Medical Journal	$30,286.68	
Less: Investment in Wisconsin Medical Journal—Deficit	22,957.99	7,328.69
Due from Wisconsin Physicians Service		19,926.98
Due from Employee's Pension Plan		615.96
Investments		8,412.50
Dividends Receivable		25.00
Accrued Interest Receivable		18.15
Guarantee Deposit		425.00
Unexpired Insurance		76.71
Total Current Assets		$137,247.09
Long Term Assets		
Loan Receivable (See Note 3)		20,000.00
Fixed Assets		
Furniture and Equipment	$41,616.59	
Less: Accumulated Depreciation	33,674.88	
Total Fixed Assets		7,941.71
Prepaid Expenses and Deferred Charges		
Prepaid Postage and Deposits	$ 7,041.20	
Inventory of Forms and Office Supplies	8,824.40	
Other Deferred Expense	5,785.65	
Total Prepaid Expenses and Deferred Charges		21,651.25
TOTAL ASSETS		$186,840.05
LIABILITIES AND CAPITAL		
Current Liabilities		
Accounts Payable		$ 30,568.13
Dues Held for Section on Ophthalmology		12,641.83
Accrued Payroll Taxes		24,163.57
Other Payroll Deductions		880.71
Accrued Employees Insurance		2,923.48
Accrued Employee Pension Plan Contribution		2,264.38
Accrued Property Taxes		14,264.39
Unallocated Dues		184.40
Accrued Expense		3,288.96
Total Current Liabilities		$ 91,179.85
Deferred Income		
Prepaid Membership Dues	$46,305.00	
Other Prepaid Income	9,818.50	
Total Deferred Income		56,123.50
TOTAL LIABILITIES		$147,303.35
NET WORTH		
Capital of General Fund 1/1/70	$10,347.69	
Excess—Income over Expense—1970	45,521.33	
Increase (Decrease) in Capital Invested in Wisconsin Medical Journal	(16,332.32)	
TOTAL CAPITAL 12/31/70		39,536.70
TOTAL LIABILITIES AND CAPITAL		$186,840.05

NOTES:

(1) Reserves of Wisconsin Physicians Service, a division of the State Medical Society of Wisconsin, are not included in this statement.

(2) The interest in SMS Realty Corporation is not carried as an asset of the General Fund.

(3) This loan is receivable from the Professional Association for Civic Education. It bears no interest. We confirmed the balance directly with the Association. Upon examination of the Association's financial statements it appears that as of December 31, 1970 they did not have sufficient funds to pay the balance of this loan.

(4) Employees earn vacation based on length of service. In the event of termination of employment an employee would be eligible for additional termination pay in the amount of earned but unused vacation. The State Medical Society as the sole employer is liable for this earned but unused vacation pay.

Under current operating procedures the vacation pay is charged to the organization for whom the employee performs services at the time. Thus at December 31, 1970 the State Medical Society has a liability for this earned but unused vacation pay although a portion of the cost of this will be borne by its related organizations at the time it is used. This liability has not been recognized in its accounts.

STATE MEDICAL SOCIETY OF WISCONSIN

General Fund

Madison, Wisconsin

STATEMENT OF INCOME AND EXPENSE

Year Ended December 31, 1970

INCOME			
Members 1970 Dues			$550,875.50
Members Dues—Prior Years			1,043.00
Dues—Academy of Medical History			1,122.50
Annual Meeting			26,529.72
Administrative Services			5,292.80
Miscellaneous Income			(288.79)
Income on Funds Invested			7,571.57
TOTAL INCOME			$592,146.30
EXPENSE			
Payroll	$220,147.07		
Less: Payroll Recovered	519.75	$219,627.32	
Insurance—Employees		7,689.24	
Retirement Plan Contributions		13,998.69	
Payroll Taxes		8,024.57	
Conference Expenses		36,065.88	
Association Dues		2,749.39	
Travel Expense—Staff		18,278.49	
Telephone		7,113.92	
Resource Material		1,479.82	
Printing and Forms		37,534.87	
Postage		12,767.72	
Office Supplies		3,409.42	
Promotion		7,259.57	
Insurance—General		3,538.77	
Grants and Appropriations		31,741.00	
Cafeterial Expense		2,331.15	
Speakers Expense		3,654.50	
Outside Services		30,913.62	
Miscellaneous Expense		3,798.69	
Auditing and Accounting Consultation		5,500.75	
Legal Counsel		20,424.90	
SMS Legislative Retainer		14,300.00	
Depreciation		2,762.75	
Rent—Central Office		49,550.88	
Rent—Other		2,400.00	
Rental of Equipment		1,457.11	
Equipment Repair and Maintenance		831.93	
Personal Property Tax		996.51	
Total		$550,201.46	
Less: Portion of above Expenses Recovered by Services Furnished to Others		3,576.49	
TOTAL EXPENSES			546,624.97
Excess Income Over Expense			$ 45,521.33

NOTES:

(1) The above excess of income over expense for 1970 is closed to the net worth accounts as follows:

To Capital Surplus	($ 1,368.58)
To Unappropriated Surplus	46,137.36
Total—General	$ 44,768.78
To Academy of Medical History	752.55
Total	$ 45,521.33

Reference Committees of the House

REFERENCE COMMITTEE ON FINANCES—Doctors W. G. Kendell, Fond du Lac; L. W. Chosy, Madison; A. H. Stahmer, Wausau (chairman); P. G. LaBissoniere, Wauwatosa; and T. E. Dugan, Waukesha.

REFERENCE COMMITTEE ON RESOLUTIONS AND AMENDMENTS TO THE CONSTITUTION AND BYLAWS—Doctors W. E. Wright, Mondovi; J. M. Jauquet, Ashland; (Joan Pyre, committee secretary); W. E. Finlayson, Milwaukee (chairman); R. A. Starr, Viroqua; and J. R. McKenzie, Jr., Oshkosh.

REFERENCE COMMITTEE ON REPORTS OF STANDING COMMITTEES—Doctors J. K. Scott, Madison; Roger Laubenheimer, Milwaukee; P. W. Wallestad, Port Washington; Antoinette Barrette, Peshtigo (chairman); and (H. B. Maroney, committee secretary). Dr. J. W. Maxwell, Jr. of Milwaukee also was a member.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS—Doctors F. A. Karsten, Horicon; P. J. Stuff, Bonduel; D. J. Carlson, Milwaukee (chairman); W. H. Williamson, Racine; and D. L. Morris, La Crosse.

OF THE 30 SCIENTIFIC EXHIBITS displayed at the 130th annual meeting of the State Medical Society at the Sheraton–Schroeder Hotel in Milwaukee in May, there were five special merit awards granted. The winners appear elsewhere in this issue. Above, Dr. Carl J. Levinson of Mount Sinai Medical Center, Milwaukee, is shown with his exhibit of "Laparoscopy."

Council Award Presented to Charles Crownhart

The State Medical Society of Wisconsin granted its highest honor—The Council Award—to Charles H. Crownhart of Madison who retired at the end of 1970 as Society secretary after 29 years of service, during the Society's annual House of Delegates sessions, May 9–11, in Milwaukee.

The award is granted only upon occasion and with rare exception to one other than a physician. In the 42 years since it was established, 36 awards have been made. Presentation of the award was made by Dr. E. J. Nordby of Madison, chairman of the State Medical Society's Council.

Mr. Crownhart

Dr. Nordby said that "of those who have been its (Council Award) recipients, it may be said that they have personified the highest ideals in their devotion to the public good."

Mr. Crownhart, a lawyer, directed the affairs of the State Medical Society following the death of his brother, George, in 1942 until his retirement at the end of 1970. Under his direction, the Society's present medical care plan, WPS–Blue Shield and the usual, customary and reasonable fee concept were founded. The Charitable, Educational and Scientific Foundation, which operates the Museum of Medical Progress as well as many other charitable and scientific programs, was initiated. All of these have become recognized nationally as methods of implementing projects of lasting value to the public and the profession.

The Award described Mr. Crownhart "as a man who doesn't forget family, doesn't forget friends, doesn't forget principle, and doesn't forget goals."

It also recognized Mr. Crownhart's "foresighted philosophy which has enabled him to render unstinting service to his profession, to the medical profession, and to the public," by quoting these words written by Mr. Crownhart in 1942:

> "Let us appreciate that the free competitive spirit of the American people permits no domination of self-thought or independence. Let us give heed not alone to the accomplishments of medicine and of our social structure, but to the freedom with which they are available to each of us. And to them attach a true sense of values that, as we approach an era in which our nation may be instrumental in securing a form of ultimate peace and tranquility throughout the world, we may place each of our endeavors in its proper niche of importance."

RESIDENT–INTERN PAPERS PROGRAM

1971 Annual Meeting, State Medical Society
May 10–12, Milwaukee

Winners

WILLIAM S. MIDDLETON AWARD: $100
IAIN T. BOYLE, MD, Madison; Fellow, University Hospitals: *A New Concept Regarding the Etiology of the Vitamin D Resistance Accompanying Renal Failure*

HARRY BECKMAN AWARD: $100
JOHN L. HUSSEY, MD, Madison; Resident, University Hospitals: Bone Marrow Transplantation—*A Solution to Renal Allograft Rejection in Adult Canines*

Medical Students Accept Houghton Award

Two senior medical students from Wisconsin's medical schools received the J. H. and W. J. Houghton, MDs Award during the House of Delegates sessions at the Annual Meeting of the State Medical Society of Wisconsin May 9–12 in Milwaukee.

Daniel Leicht of the University of Wisconsin Medical School and Winston Hollister of the Medical College of Wisconsin were presented the award by Dr. William D. Stovall, president-emeritus of the State Medical Society's Charitable, Educational and Scientific Foundation which administers the memorial fund.

The award consists of $100 to each recipient and an inscribed plaque. It is granted annually to "one or more students who, through scholastic excellence, extracurricular achievement and interest in medical organization, show high promise of becoming a complete physician."

The award was named after John H. Houghton, MD of Wisconsin Dells and William J. Houghton, MD of Milwaukee, brothers who were former councilors of the State Medical Society. Dr. John Houghton also served as president of the Society.

Before their deaths, the Doctors Houghton jointly endowed the award for medical students. Their hope was that the distinction would encourage young men and women "to a greater appreciation of the need for physicians to work together in their county, state, and national medical organizations and to achieve a well-rounded education including the socio-economic, as well as the scientific."

Both young men graduated this month. Doctor Leicht is from Racine, Doctor Hollister from Milwaukee. The latter will be interning at Milwaukee County General Hospital.

DR. WILLIAM D. STOVALL, left, is shown with the two medical student recipients of the Houghton Award, Daniel Leicht, his girl friend, Mrs. Hollister, and Winston Hollister.

Wis. Medical Schools Receive $23,280 Through AMA–ERF

Private funds totaling $23,280.23 were contributed to the two Wisconsin medical schools during a special presentation at the State Medical Society's House of Delegates' sessions in Milwaukee in May.

The University of Wisconsin Medical School received $8,621.43 while the Medical College of Wisconsin was given $14,658.80. Receiving the checks were the two medical school deans, Dr. Peter L. Eichman of the UW and Dr. Gerald A. Kerrigan of the MCW.

Presenting the checks was Dr. W. D. James of Oconomowoc who noted that "the funds may be used at your discretion, for whatever projects you determine to be in the best interest of your school."

The grants are part of $955,725 contributed in 1970 by physicians, their wives (Woman's Auxiliary

continued on next page

PAST PRESIDENTS—Thirteen of the 17 remaining past presidents of the State Medical Society got together with the Society's current president, Dr. George A. Behnke, during the Annual Meeting in May in Milwaukee. They are: standing, left to right, Doctors W. J. Egan, Milwaukee; N. A. Hill, Madison; L. H. Lokvam, Kenosha; Robert E. Callan, Milwaukee; L. O. Simenstad, Osceola; H. K. Tenney, Madison; J. C. Griffith, Milwaukee; M. A. McGarty, La Crosse; and Behnke; seated, Doctors W. P. Curran, Antigo; F. E. Drew, Lighthouse Point, Fla.; J. W. McRoberts, Sheboygan; E. L. Bernhart, Milwaukee; and H. J. Kief, Fond du Lac.

THE TWO WISCONSIN MEDICAL SCHOOL deans receiving their AMA–ERF checks totaling $23,280.23 from Dr. W. D. James, Oconomowoc, at right. At left and center are Doctors Gerald A. Kerrigan of the Medical College of Wisconsin and Dr. Peter L. Eichman of the University of Wisconsin Medical School.

AMA–ERF/*continued*

to American Medical Association), medical societies, and other sources through the American Medical Association Education and Research Foundation (AMA–ERF) to medical schools in the U.S. and Canada.

Since 1960, AMA–ERF has contributed $280,000 to Wisconsin medical schools, and more than $12,000,000 nationwide. Some contributions are designated to specific schools; undesignated funds were divided among 103 medical schools this year.

DR. JOHN P. WYATT, left, of Winnipeg, Canada, receiving the William Beaumont Memorial Lecture Award from Dr. Leland C. Pomainville of Wisconsin Rapids.

Minnesota Doctor Presented Elvehjem Lecture Award

Dr. Harry S. Jacob of Minneapolis, Minn., received the Elvehjem Memorial Lecture Award during the 130th annual scientific meeting of the State Medical Society, held at the Sheraton–Schroeder Hotel in Milwaukee, May 10–12.

continued on next page

DR. HARRY S. JACOB of Minneapolis, Minn., is shown receiving the Elvehjem Memorial Award from Dr. Robert M. Senty of Sheboygan. Dr. Anthony V. Pisciotta of Milwaukee appears in the center. He was general program chairman of the State Medical Society's annual scientific meeting which was arranged by the Society's Commission on Scientific Medicine.

Canadian Pathologist Given Beaumont Lecture Award

Dr. John P. Wyatt of Winnipeg, Canada, was this year's recipient of the Beaumont Memorial Lecture Award during the State Medical Society's Annual Scientific Meeting in Milwaukee in May.

Dr. Wyatt, professor and head of the Department of Pathology, University of Manitoba, accepted the award from Dr. Leland C. Pomainville of Wisconsin Rapids, treasurer and a trustee of the Society's Charitable, Educational and Scientific Foundation which administers the memorial fund.

His lecture was entitled, "The End Stage Lung."

The award is given annually to an outstanding physician in the United States to honor William Beaumont, MD, a pioneer physician whose experiments on the human stomach during military duty at Fort Crawford in Prairie du Chien gained national recognition.

In making the presentation, Dr. Pomainville stated that although Dr. Wyatt was a pathologist, he was invited to give the memorial lecture before the Section on Surgery because of his reputation and work in diseases of the chest.

Photography Awards

The doctor who is a photography bug was given the opportunity to show his expertise in a photographic competition held in conjunction with the 130th Annual Meeting of the State Medical Society, held in Milwaukee at the Pfister and Sheraton–Schroeder hotels, May 9–12.

Competition was unusually keen and in four of the five categories there were more than 25 entries. A list of the prize-winning entries follows:

Best in Show: "The Discussants" by Dr. James R. Hoon of Sheboygan.

Travel: First place—"Hurricane Camille After-Math," Dr. John Erbes, Milwaukee; second—"Pelikanen Stripper," Dr. James R. Hoon, Sheboygan; third—Dr. Sheldon L. Burchman, Milwaukee; honorable mentions—"Guardian Hakone Shrine," Dr. James R. Hoon, Sheboygan, and "Camelot," Dr. Sheldon L. Burchman, Milwaukee.

People: First place—"The Discussants," Dr. James R. Hoon, Sheboygan; second—"The Way It Is . . . ," Dr. Stuart D. Wilson, Milwaukee; third—"Orphan," Dr. Stuart D. Wilson, Milwaukee; honorable mention—"Pigeons and People," Dr. M. G. Peterson, Lake Mills.

Medicine: First place—"Umbilical Hernia," Dr. Joseph L. Teresi, Brookfield.

Animals: First place—"Barred Owl," Dr. Noland Eidsmoe, Rice Lake; second—"Unbridled Power," Dr. John Erbes, Milwaukee; third—"Montage-Great Barrier Reef," Dr. M. G. Peterson, Lake Mills; honorable mention—"Mountain Monarch," Dr. Noland Eidsmoe, Rice Lake.

Pictorial: First place—"Gleam of Hope," Dr. Werner A. Hauschild, Kenosha; second—"Til We Meet Again," Dr. Sheldon L. Burchman, Milwaukee; third—"One Year After Hurricane Camille," Dr. John Erbes, Milwaukee; and honorable mentions—"Window Shopping," Dr. Sheldon L. Burchman, Milwaukee, "Winter's Keyboard," Dr. Joseph L. Teresi, Brookfield, and "Tidal Victim," Dr. Marvin G. Peterson, Lake Mills.

SPECIAL MERIT AWARDS FOR BEST SCIENTIFIC EXHIBITS

1971 Annual Meeting, State Medical Society May 10–12, Milwaukee

- Mario De Oliveira, MD, Columbia Hospital, Milwaukee: *Electromyogram and Neuromuscular Diseases*
- Carl J. Levinson, MD, Mount Sinai Hospital, Milwaukee: *Laparoscopy*
- Bernard Messert, MD, VA Hospital, Madison: *Gait Disturbances in Adult Obstructive Hydrocephalus*
- James E. Auer, MD; W. Dudley Johnson, MD; Alfred J. Tector, MD; Robert J. Flemma, MD; Derward Lepley, MD, Jr., Medical College of Wisconsin, Milwaukee: *Direct Surgery for Coronary Disease Using Saphenous Vein Bypass Grafts*
- Michael Thimmesch, MD; John Grogan, MD, St. Joseph's Hospital, Milwaukee: *Cervical Spondylosis*

ELVEHJEM AWARD/*continued*

Dr. Jacob, who is Chief of the Section of Hematology and Professor of Medicine at the University of Minnesota Medical School, accepted the award from Dr. Robert M. Senty of Sheboygan, a member of the Society's Charitable, Educational and Scientific Foundation Executive Committee. His lecture was entitled, "Hereditary Spherocytosis Mechanisms and Treatment."

The award honors Conrad A. Elvehjem who was an international authority in biochemistry. He also was an eminent teacher and administrator who served as the 13th president of the University of Wisconsin.

The award is presented by the Society's Charitable, Educational and Scientific Foundation, which administers the Elvehjem Memorial Fund.

Woman's Auxiliary Medical Art Salon Awards

The tenth annual Medical Art Salon of the Woman's Auxiliary to the State Medical Society again was a favorite with exhibit viewers at the Society's 130th Annual Meeting May 9–12 in Milwaukee.

For the fourth consecutive year, Dr. John Erbes of Milwaukee captured the Popularity Award with his watercolor painting of *Indian Legend Creek*. Dr. Guy W. Carlson of Appleton received second prize in special recognition of his painting, *Autumn in Vermont*.

This year for the first time, acrylics was added to the categories and the following are the awards:

ACRYLICS

1. Dr. William F. Hovis, Jr., Milwaukee, *Jamaica*
2. Mrs. George Savage, Port Washington, *Double Image*
3. Mrs. Louis Fazen, Jr., Racine, *Mary Ellen*

WATERCOLOR PAINTING

1. Dr. Hania Ris, Madison, *Reflections*
2. Mrs. Donald Luedke, Brookfield, *Chinese Junks*
3. Dr. John Erbes, Milwaukee, *Indian Legend Creek*

OIL PAINTING

1. Mrs. Donald Bravick, Appleton, *Alone Together*
2. Dr. William F. Hovis, Jr., Milwaukee *Carousel*

SCULPTURE

1. Mrs. Herry Kijner, Milwaukee, *Moses Undisturbed Waiting for Godat*
2. Dr. Werner Hauschild, Kenosha, *Mister B*
3. Dr. T. A. Leonard, Middleton, *Standing Mother & Child*

Co-chairmen of the Medical Art Salon this year were Mrs. Richard Bourne and Mrs. John Weber, both of Milwaukee.

Judge of art was Professor Robert Burkert of the department of art at the University of Wisconsin—Milwaukee.

GOVERNOR'S SPECIAL MESSAGE TO THE LEGISLATURE

Health and Health Care in Wisconsin

On May 18 Governor Patrick J. Lucey addressed a joint session of the Legislature on health and health care in Wisconsin.

This far-reaching and significant message is of utmost importance to every physician in Wisconsin; therefore, major points in the Governor's message are excerpted here.

. . . We now have the need and the opportunity during the 1970's to improve outdated and inefficient techniques of health education and delivery, and to improve preventive care. We have the opportunity to establish this decade in Wisconsin as one of unparalleled achievement in the field of health. To accomplish this will require the involvement of government, the health professions, the educational system and all of our state's citizens.

It is indeed paradoxical that at the very time when we are experiencing dramatic breakthroughs in biomedical science and research, we are still unable or unwilling to provide adequate health care for all of our citizens.

I can think of no field where there is more being done, by more people, than in health, and of no field where there is greater fragmentation of effort. This lack of clear responsibility and planning has produced disparities in the quality of care available to our various citizens, a manpower shortage in health and health related professions, inefficient use of facilities and services, staggering cost increases and ignorance on the part of health consumers.

. . . In the past, we have looked to the health professionals to chart the paths that health care and treatment should follow. We have encouraged physicians, dentists, nurses, technicians, therapists and others to determine the manner in which health care should be organized, delivered, and financed. This has resulted in each provider individually defining the community he serves and the needs of that community for health services.

. . . Effective planning can only be accomplished with the involvement of the citizens to be served. The unit of planning for the future must be *a population*. In our case it should be the population of Wisconsin. If we apply a population-centered strategy of planning we can insure that all citizens are included.

The challenge of the future is this: to develop a mechanism which permits public and private providers of care and the community to come together and assess health needs and determine the role and responsibility of providers in meeting these needs. No one group can plan alone; our experience to date has made this clear.

My comments about the lack of coordination in health planning are not intended as an indictment of the health professionals. Rather, they are intended to suggest that solely charging the professionals with defining the public health mission has been a mistake and an abdication of responsibility on the part of government.

The health professionals must insure that the public is well educated and aware of the relationship between the quality of life and good health. They should refine the understanding of public officials and provide them with information about the impact of alternative decisions on the quality of life that citizens will enjoy. They should continue to use their expertise in doing curative research, urging measures which will prevent disease and promote good health and in treating the individually sick. But these experts ought not to be vested with the primary responsibility for community health planning. Planning for community health is a social responsibility of government, along with the health professions, the educational system and the citizens themselves.

In the past, both on the national and the state level, government has shirked its responsibility to furnish leadership.

. . . An even greater problem is citizen knowledge of and access to health care. The consumer lacks not only the knowledge of how to use the system, but also standards by which to judge the care received. In many ways, the system, or rather the nonsystem, has failed.

We need a system which allows the consumer to express his aspirations and desires, the government its priorities and the professional his expertise . . . all blended into a program to provide maximum quality health care.

. . . We must develop sound plans for an improved system of health care for Wisconsin. We must set our priorities and develop the policies by which we will accomplish this goal. We must do this together—government (both the legislature and the executive), the health professions, the educational system and the people.

It is apparent, I think, that if we are to meet the health care needs of our citizens nothing short of very significant action must be undertaken. I am therefore announcing today the creation of a Health Planning and Policy Task Force. I have asked for and received the consent of one of Wisconsin's most capable citizens to lead this Task Force—Mr. David Carley of Madison.

Invitations have been extended to approximately 40 citizens without regard to political affiliation. I will also invite six legislative leaders, three Republicans and three Democrats, to act as advisors to the Task Force.

I am charging this Task Force with the responsibility of developing a comprehensive health plan and policy for the State of Wisconsin. I want this plan to be so excellent, so comprehensive and so outstanding that it can serve as a model for the nation.

I will instruct the Task Force to ascertain the health needs of our citizens and to design a comprehensive system which will provide the services health consumers require. The Task Force will work to develop realistic health and health service goals. I will also ask it to compile a health plan, designate health priorities, recommend a legislative program and suggest any necessary administrative reorganization. It will identify the responsibility for government, the providers,

the educational system and the consumers. I will also ask for its recommendations on the financing of health care, utilizing both public and private capital. And I have requested early identification of those areas demanding priority attention.

The Task Force and its staff will be given 18 months from June 1, 1971 to complete this important undertaking.

. . . As an additional measure, I have by executive order, created a Health Policy and Program Council. I have asked for and received the consent of one of Wisconsin's outstanding physicians to lead this Council, Dr. Ben Lawton of Marshfield. This Council will combine into one more efficient body, five existing councils which are charged with administering federally funded programs: comprehensive health planning, developmental disabilities, hospital construction, mental health centers construction and facilities for the mentally retarded. The intent of this action is to overcome serious inefficiencies fostered by the federal government in its separate program requirements over the past two decades. Local communities, state agencies and the executive office will now realize the benefits of consolidated administration and single point, consumer-dominated advice on this Council. There will be some overlap of membership between the Council and the Task Force to insure coordination between the on-going federal programs and the state plan developed by the Task Force.

. . . Not only is there a shortage of physicians but there is a particular and worsening shortage of generalists and primary-care physicians. The most severe burden of the manpower shortage is borne by family physicians, a role now primarily served by internists and pediatricians. The efficiency of a complex system of highly specialized consultants is dependent on an adequate number of broadly based physicians who are especially capable of providing the bulk of comprehensive care and coordinating the work of consultants when necessary.

We are fortunate, in Wisconsin, to have two medical schools of high quality. Our continued support of both the University of Wisconsin Medical School in Madison and the Medical College of Wisconsin in Milwaukee is necessary if we are to respond to the problems I have outlined. Both schools have serious problems in program support and the creation of adequate, modern facilities for educational service. We must examine these needs carefully and promptly. It is my belief that both schools can, with appropriate support, increase their class sizes substantially. There is also good reason to believe that we can expand our clinical education and associated residency programs by utilizing community hospitals and medical groups in the state. Although the 1967 Task Force suggested a possible need for a third medical college, the long start-up time and the large amount of required initial funding, indicates that we should first strive for maximum enrollment expansion at the existing two schools. The University of Wisconsin Medical School and the Medical College of Wisconsin in Milwaukee are complementary in several important ways.

The UW Medical School must remain in Madison and must continue to capitalize on the strength of its relationship to the rest of the University, particularly to the biomedical sciences. Phase I of the medical center building program is an important step in insuring this continued relationship.

The Medical College of Wisconsin, by virtue of its location, should concentrate on serving the health needs of metropolitan Southeastern Wisconsin. The Medical School here in Madison has, and probably should continue, to concentrate on the health problems characteristic of the less-metropolitan remainder of the state. Cooperative programs between the two schools should be encouraged as should cooperative programs between the Medical College of Wisconsin and UW–M.

. . . I would hope that as one of his first actions the new Vice Chancellor will look into the problem of recruiting medical students from minority groups and rural areas. Studies have shown that doctors tend to practice among people who are similar to those with whom they have been reared. We must intensify our efforts to recruit from urban and rural groups whose present need for more trained professionals is most urgent. We must also be more attentive to developing and training para-medical personnel and licensing those already qualified. This in turn calls for an evaluation of whether we can not better use the time of our most highly trained medical personnel by delegating some of their functions to others who will work under their supervision.

. . . I commend the State Medical Society for taking the initiative in recommending legislation to license para-medical personnel. With minor modification, I fully support this measure.

I encourage the Assembly to pass rapidly Senate Bill 32 (Sub 1) which calls for the continued development of areawide health planning.

. . . I also endorse Senate Bill 51, which in part, allows new informal admission procedures for people entering mental hospitals and provides citizens with important constitutional protections against inappropriate commitment.

Assembly Bill 206 requiring drugs to be prescribed by their generic names will benefit consumers. The intent of the bill is good. However, it should be modified slightly to protect needed physician prerogatives in the interest of patient care; and it should not require a generic enumeration for certain medication containing extensive combinations of drugs.

I also encourage the passage of Assembly Bill 367 which requires the training, examination and licensing of ambulance attendants and managers. Forty-six percent of Wisconsin's ambulance attendants have not even received minimal Red Cross standard first aid training. In at least 10 percent of all ambulance calls, the patient's life depends upon the expertise of the ambulance crew.

. . . In the near future I will request the introduction of legislation creating a certificate of need program for health facilities in Wisconsin.

. . . Serious attention must be given to the optimum manner for linking hospitals throughout the state. This is especially critical for rural areas where rising costs have forced the erosion of small and autonomous facilities and threatened the quality of care. In order for hospitals and group practices to survive in rural areas they must be provided the linkage to larger medical centers which have more complex equipment and larger staffs of specialists.

continued on next page

Narcotics Registration Deadline Extended

The deadline for use of physician registration numbers under the Controlled Substances Act has been extended to July 29, the Bureau of Narcotics and Dangerous Drugs (BNDD) announced.

The law went into effect May 1, but the Bureau said physicians who have applied for registration but who have not received their BNDD numbers may continue to practice without interruption by indicating "Federal registration applied for on (date)" instead of the BNDD registration number. After July 29, the Bureau said, "no activity with controlled substances will be permitted without use of a valid BNDD registration number."

The law requires every person, not specifically exempted, who manufactures, distributes, prescribes, administers, or dispenses any controlled substances, to register annually with the Attorney General.

This registration function has become the responsibility of the Bureau of Narcotics and Dangerous Drugs.

Previously such registration was required under the Harrison Narcotic Act or the Marihuana Tax Act with the Internal Revenue Service.

HEALTH CARE/*continued*

I will also introduce legislation enabling minors to obtain diagnosis and treatment of venereal disease without parental consent. This is needed to stop the near epidemic spread of this dread disease among the teenage population.

I am also introducing legislation to allow the state to seek injunctive relief against violations of the Nursing Home Licensing Act and to impose penalties for violation.

I will also introduce extremely important legislation to allow recipients of Title 19 (Medicaid) to enroll in prepaid group programs. This will enable our poor citizens to receive a more stable level of care, provide fledgling prepaid group practices with needed subscribers and provide taxpayers with a predictable cost for the total care needs of the poor.

Finally, I will introduce legislation to allow salaried physicians in hospitals to participate in health maintenance organizations. This will be a beginning in moving away from the exclusive fee-for-service basis of health care. This legislation is an important first step in helping to eliminate existing, health cost problems.

WPS Issues Statement Clarifying Medicare Assignment Method

Medicare assignment agreements in Wisconsin, in some instances, are not being fulfilled, according to information from WPS Blue Shield, the insurance carrier for the Medicare program in Wisconsin outside of Milwaukee County.

In an effort to assist physicians and their office staff in complying with the Medicare assignment agreements, WPS has issued the following statement:

MEDICARE ASSIGNMENT AGREEMENTS

Without regard to assignment, the Part B carrier must determine if the professional charge for a service is a reasonable charge as prescribed by Medicare Regulations and reimburse the physician or patient accordingly. Reimbursement based on such determination is subject to the deductible and co-insurance provisions of the Law and constitutes the total amount reimbursable by the carrier.

A physician accepting an assignment of benefits from a Medicare Part B beneficiary patient *is entitled to reimbursement direct from the carrier.* When assignment is accepted and a claim submitted to the carrier, the assignment agreement may not be withdrawn or altered as to that particular claim. If the physician disagrees with the reasonable charge determination, he has the traditional avenues of recourse to seek further consideration for review of determinations involving unusual or complicated procedures, and in addition, he is entitled to seek and receive a Fair Hearing under the Medicare Laws.

If an assignment is accepted, the beneficiary remains responsible to the physician for that portion of the reasonable charge determination applied pursuant to the $50 deductible and 20% co-insurance provisions. The total of reimbursements for a physician's charge from carrier, patient, or *third party source* may not exceed the allowed reasonable charge determination for the service.

In rare instances, physicians or their assistants have forgotten the rules of assignment and have billed the patient for amounts which exceed the total reasonable charge determination for the service rendered. The carrier's attention is directed to such billing practices when the patient beneficiary complains to the local Social Security Office. The carrier is then required to conduct a sample survey of past billings of assignment cases for this physician to determine the incidence of billing for non-allowed charges. Where cases of billing for non-allowed charges are identified, the physician is required to refund or credit patients with the amounts improperly billed or collected. In flagrant cases where there is refusal to refund, the Regional Office of the Social Security Administration may authorize the carrier, after giving proper notice, to disregard the physician's future assignments and pay all patients directly.

PLEASE BE SURE YOU DO NOT COLLECT OR BILL FOR CHARGES WHICH WERE REDUCED DUE TO THE REASONABLE CHARGE CRITERIA ON CLAIMS WHERE AN ASSIGNMENT WAS ACCEPTED.

New Health Board Member

Mrs. Charles W. Vaughn of Madison recently was appointed a member of the State Health and Social Services Board succeeding Arthur P. Schmidt of Hartland who resigned. The term expires May 1, 1973.

Miss. River Rats Boost Ecology Expo with $500

The Mississippi River Rats showed their support of the nation's first ecology exposition (Eco–Expo 71) with a $500 donation to the State Medical Society's Charitable, Educational and Scientific Foundation. The exposition is on exhibit in Prairie du Chien at the Old Fort Crawford Museum of Medical Progress which is owned and operated by the State Medical Society. Dr. William D. Stovall, left, president-emeritus of the CES Foundation, recently accepted the money from Chief Rat Tom Leverich, who represented the 2,000-member organization dedicated to clean water, clean lands, and clean fun. The exposition will be open through October 31.

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EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

Swan Song

PREPARING ONE LAST EDITORIAL sounded like an easy thing to do. After twelve years of monthly expressions, a few more paragraphs, a few more thoughts, a couple of hundred more words, would be no effort. But suddenly, the enormity of the last dozen years rose up and made further expression difficult.

What makes one man's opinion worth more than that of another? Nothing, really. Except that one man has the gall or indiscretion or hubris to commit himself to writing, and the other man sensibly keeps his thoughts to himself. One man walks about with his most private self exposed to the gaze of his colleagues and subjects himself to their approval or censure, and another man keeps himself wrapped in the cloak of his own secrecy. Understandably, after twelve years of such exposure, a nonprofessional editorial writer ought to quit for the sake of his own sanity.

The last twelve years have been full of change for the medical profession. The period started before medicare and ends with the frightening prospect of universal government-furnished health care. In 1959, terms like "socialized medicine" were still being used. Nowadays they are almost dirty words, belonging in the museum of obsolete concepts. Today, the delivery of medical care is recognized as a social function of society, and there seems to be less concern with the preservation of the doctor–patient relationship than there is with the fact that such a relationship be established in the first place.

Undoubtedly the medical profession has undergone a basic change of philosophy in the last dozen years—not that there has been any widespread change of attitude on the part of individual doctors; rather, the men and women who are becoming physicians are products of new times, and they participate more intimately in the mainstream of current social attitudes. It is to the young doctors, therefore, that one looks for the dynamic that will return the profession of medicine to its former position of respect as a dedicated, selfless healer of the sick through the application of scientific knowledge.

Those conservative leaders of our profession who have tried to stand motionless in the melee of social change have helped to erode the high regard that physicians have enjoyed in the past. Too often we have, as a group, surfaced as financially oriented entrepreneurs, afraid to confront the realities of the modern condition. As a group, we have too often come out flat-footed against innovation, change, and accommodation. As a result, we have become the victims of change rather than the masters of it. It is hoped that the new doctors will benefit from the experience of the past twelve years and will show the imagination and creativity required to restore medicine to the role in the community it should have.

I am deeply in debt to those members of the Society who have encouraged me with words of approval, and I sincerely appreciate the honest expressions of difference of those who disagreed with me. To those whose objection was obscene, personal, defamatory, scurrilous and irrelevant, I return my heartfelt pity. I respect legitimate dissent, as I would expect my dissent to be respected. But for the derivative position, for the mindless adherence to a party line, whether left or right, there can be nothing but abhorrence.

I am not unmindful of the honor that the State Medical Society has given me in permitting me to be Editorial Director of its JOURNAL for so long. I have tried to fill the post with decency and integrity. I feel strongly, however, that it is an honor that should be passed around and that the position requires a freshness of approach that only a new name and a new brain can give.

So, without sentiment and without the usual journalistic ploys about —30— and ###, I say only thank you for reading. —DNG

DNG

AFTER TWELVE YEARS and 144 deadlines, Doctor David Goldstein decided not to accept reappointment as Editorial Director of the WISCONSIN MEDICAL JOURNAL. Despite our entreaties, his decision was irrevocable. We will miss his editorials and his beautiful vocabulary. Over the years these editorials, not always free of controversy, have been widely quoted in the state press and in national medical journals. And judging by the correspondence that has been stimulated, the editorials were read early and avidly.

Although never devoid of his own ideas for editorial comment, Dave always responded to requests for specific editorial material or to an occasional gentle needle. The staff and Editorial Board thank Doctor Goldstein for his twelve years of dedicated service to the WISCONSIN MEDICAL JOURNAL and to Wisconsin medicine.—V. S. FALK, MD, Medical Editor

We Shall Miss His Companionship

THROUGH THE PAST twelve years the State Medical Society of Wisconsin, its JOURNAL, and its members have been served faithfully and eloquently by the editorial excellence of Doctor David Goldstein. Despite the inevitable deadline to meet each month, the editorship is only one of several important ways that Dave served and continues to serve the Society. His editorials have never been sterile but more often have contained a leaven that has stimulated thought and discussion within (and at times without) the medical profession. Edward Weeks has said, "Editing is the most companionable form of education." We shall miss the companionship of Dave's editorials!—E. J. NORDBY, MD, Chairman of the Council

Soliloquy on Solipsism

DOCTOR GOLDSTEIN, as with most editorial writers, was wont to feel at times that he was talking to himself. Unlike some writers, however, Dave never let himself believe it. His words and observations often moved the mind of both writer and reader to new understanding via the printed word. What's more, he had fun and gave the reader enjoyment as he did it. Some ten years ago we penned these words in response to the latest neologism of our retiring Editorial Director. I suggest that the moment is at hand to change his title:

"At first I thought 'twas just by chance
That you turned the frequent artful phrase;
But now I think your mind must dance
With exotic Goldsteinisms and Kenoshaise.
In fact I think it would be much correcter
If we could without suspicion
Change your title from Editorial Director
To something like Chief Rhetorician."

—ERT

The New Editorial Director: Raymond Headlee, MD

THE COUNCIL OF THE State Medical Society of Wisconsin has appointed Raymond Headlee, MD of Elm Grove to succeed David N. Goldstein, MD of Kenosha as the Editorial Director of the *Wisconsin Medical Journal.*

In his new position, Doctor Headlee will be responsible for the content of the Editorial section. The views expressed in the editorials, if initialed or signed, are those of the writer and not necessarily official positions of the Society. Through the years the *Wisconsin Medical Journal* editorials have received national and sometimes international attention.

Doctor Headlee becomes Editorial Director with an extensive background in writing and editing. In 1949, he was co-author with Bonnie Corey, RN, of a textbook titled, "Psychiatry in Nursing." He has contributed articles to national and international publications in psychology and psychiatry as well as to the *Wisconsin Medical Journal.*

Dr. Headlee

An enthusiastic writer, Doctor Headlee has written more than 35 essays for the *Milwaukee Medical Times* covering both social and political subjects. He is senior editor of *Transactions,* a publication of the

Department of Psychiatry, Medical College of Wisconsin.

For more than a year, Doctor Headlee has been writing—under the name of The Medical Society of Milwaukee County—a popular column called "Ask the Doctor" for the *Milwaukee Journal*.

Doctor Headlee has been in the private practice of psychiatry since 1949, initially in Milwaukee and now in Elm Grove.

Born July 27, 1917, in Shelby County, Indiana, Doctor Headlee began his formal training with an BA degree in 1939 and an MA in 1941 in experimental psychology from Indiana University; he received his MD in 1944 from Indiana University School of Medicine, Indianapolis.

His internship was taken at St. Elizabeth's Hospital in Washington, D. C. where he continued a residency program in psychiatry. He completed residency training at Milwaukee Sanitarium, now called Milwaukee Psychiatric Hospital.

Doctor Headlee was certified in psychiatry in 1951. Since 1963 he has been an assistant examiner of the American Board of Psychiatry and Neurology which honored him with a commendation in 1969.

Doctor Headlee has had teaching appointments in psychology at Indiana University, George Washington University, and the University of Wisconsin—Milwaukee. He has been professor of psychology at Marquette University since 1966.

At the Medical College of Wisconsin, formerly Marquette University School of Medicine, Doctor Headlee advanced from an assistant clinical professor of psychiatry in 1958 to chairman of the Department of Psychiatry from 1963 to 1970.

Doctor Headlee belongs to a number of organizations in psychology, medicine, and psychiatry. Since 1940 he has been a member of the American Psychological Association, charter member and first secretary of the Wisconsin Psychological Association, and is a licensed psychologist in Wisconsin.

Doctor Headlee became a fellow of the American Psychiatric Association in 1951 and a fellow of the American College of Psychiatrists in 1969. As a member of the Wisconsin Psychiatric Association, Doctor Headlee was founder and editor of its newsletter for six years and served in various offices. He is currently president-elect.

A member of the American, State, and County medical societies, Doctor Headlee has been a member of the Editorial Board of the Milwaukee County Medical Society since 1965. Doctor Headlee served for seven years as a member of the State Medical Society's Division on Nervous and Mental Diseases.

He is a member of the consulting staffs of Milwaukee Children's, Lutheran, St. Luke's, Waukesha, and Elmbrook hospitals, as well as a member of the Board of Directors of Elmbrook Memorial Hospital, Brookfield.

He has been president of the medical staff of Milwaukee Psychiatric Hospital since 1967 and manager of the Kradwell Visitor Program the past three years.

In 1965 Doctor Headlee attained the rank of Medical Director in the reserve corps of the United States Public Health Service after serving 15 months, including an assignment with NIMH and Region V as consultant.

Doctor Headlee and his wife, Eleanor, whom he married in 1941, have three children: Sue, who is married; Mark, in graduate school; and Ann, a sophomore in college. □

Find your future in the HEALTH FIELD

. . . a career guide

"Find your future in the health field," urges a brochure published by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

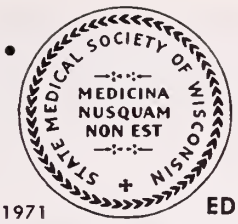
The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

SECTION



OPHTHALMOLOGY

JUNE 1971

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

SECTION MEETING IN MILWAUKEE

The Section on Ophthalmology of the State Medical Society met for a luncheon and business meeting at the Sheraton–Schroeder Hotel in Milwaukee, May 12, during the Annual Meeting of the State Society, May 9–12.

Fifty-six ophthalmologists attended the meeting which was conducted by the Section chairman, John E. Conway, MD, Menasha.

Kenneth T. Richardson, Jr., MD of Pittsburgh, a guest lecturer on the afternoon ophthalmology program, was introduced. He is chairman of Ophthalmology of the University of Pittsburgh.

The minutes of the previous meeting in 1970 were approved as printed in the *Wisconsin Medical Journal,* July 1970 issue.

The following committee reports were presented:

House of Delegates, reported by George H. Anderson, MD of Stevens Point:

(1) Discussed reports and resolutions presented to the House.

(2) Noted in particular two resolutions concerning the use of silver nitrate for prophylaxis of ophthalmia neonatorum. Reported that the House turned down a recommendation that an investigation of other agents be undertaken and voted to continue the use of silver nitrate for another year.

(3) Reported that the House had approved Resolution JJ as amended. It requested the State Medical Society to "encourage the Woman's Auxiliary to pursue the development of programs for preschool eye and ear testing in those areas in which no similar programs now exist; and to cooperate with, support, and assist in those programs currently providing such services."

(4) Pointed out that the report of the Division on Vision and Visual Standards Committee stated that from driver license examinations there were approximately 1% referrals of the 400,000 persons examined for driver licenses.

Legislative Committee, reported by Elmer Johnson, MD, Madison:

(1) Discussed two bills that were introduced in the Legislature during the past year, one concerning safety glasses and the other on licensing of opticians.

(2) Accepted a supplemental report from a member of the State Society's legislative staff regarding a pending bill on the certification of physician's assistants.

American Association of Ophthalmology and *Academy Pediatrics Ad Hoc Committee,* reported by James V. Bolger, Jr., MD, Waukesha:

(1) Noted that the Milwaukee Ophthalmology Society was sending a representative to the American Medical Association's meeting in Atlantic City in June. He is Walter E. Gager, MD of Waukesha.

(2) Recommended (subsequently approved) appointment of a representative from the Section to attend the AMA meeting to participate in discussions concerning dyslexia and reading disabilities.

(3) Reported the AAO's position regarding the impact resistant lens—that it should be a matter of concern to the American Standards Committee and not a legislative issue.

(4) Reported that the soft contact lenses would probably be classified as a drug and would be under control of the FDA.

Committee on Vision, reported by George Nadeau, Jr., MD, Green Bay:

(1) Remarked that some educators were referring patients with slight dyslexia to non-qualified persons and further stated that the Division on Vision of the State Medical Society should cooperate with the Woman's Auxiliary in developing preschool eye and ear examinations.

(2) Stated that the motor vehicle examination should stress the feeling that physicians should be concerned with determination of degree of *impairment* but not with the degree of *disability.*

(3) Allowed a question from the floor by Harry A. Easom, MD of Milwaukee as to whether anything was being done at the state level to resolve the present referral situation concerning slight dyslexia cases. The answer was given by James V. Bolger, Jr., MD of Waukesha who stated that it was illegal to discriminate in such referrals.

(4) Regarding the driver license form, Ralph T. Sproule, MD, Milwaukee, reported that new forms were being developed.

Clemens Kirchgeorg, MD, Neenah, further elaborated on the driver license situation. He stated that the confrontation field should suffice for visual field determination, and ophthalmologists should object to the requirements of right-sided mirrors on cars for monocular patients and those with vision acuity less than 20/400.

(5) Additional remarks were made by Herbert Giller, MD, Milwaukee, questioning the obligation of the examining ophthalmologist to report elder pa-

continued on page 52

tients who were incapable of driving at that point. George Nadeau, Jr., MD, Green Bay, gave the reference for visual factor of auto driving as being the *Archives of Ophthalmology*, vol. 81, June 1969, page 864.

Education Committee, reported by Matthew D. Davis, MD, Madison:

(1) Encouraged each member present to visit the ophthalmology exhibit by the University of Wisconsin Medical School, Madison.

(2) Inquired as to the interest of the group in having a telephone consultation service set up for Ophthalmology.

(3) James C. Allen, MD, Madison, announced the meeting of the Wisconsin–Upper Michigan Ophthalmology Society, on October 23 at Lake Delton.

Knight Templar Eye Foundation, reported by Ralph T. Rank, MD, Milwaukee:

Noted that one of the purposes of the Foundation is to aid the medically indigent patient. Last year the Foundation aided 128 persons in Wisconsin. Approximately $4.5 million has been spent by the Foundation in aiding eye patients. Brochures were distributed to the members.

A financial report noting the income and itemized expenditures as of April 4, 1971, was accepted.

Nominating Committee, composed of Clemens Kirchgeorg, MD, Neenah; Ralph E. Teitgen, MD, Milwaukee; and Richard W. Ashley, MD, Kenosha:

Presented the following slate of officers for 1971–72:

CHAIRMAN: Elmer E. Johnson, MD, Madison
CHAIRMAN-ELECT: George H. Anderson, MD, Stevens Point
SECRETARY: W. Carson Parks, MD, Milwaukee
DELEGATE: George Sparks, MD, Marshfield
ALTERNATE DELEGATE: Herbert Giller, MD, Milwaukee

The officers were elected unanimously and the meeting then adjourned.

Sixty ophthalmologists attended the afternoon scientific program. Dr. Richardson's topic was "Chronic Open Angle Glaucoma: Diagnosis and Therapeutic Decisions." Another speaker, Thomas R. Sawyer, MD of Milwaukee, presented a number of interesting and stimulating clinicopathologic conferences.

DR. BRIGHTBILL GOING TO FLORIDA

Frederick S. Brightbill, MD will complete his ophthalmology residency at the University of Wisconsin in July 1971. He will start a one-year fellowship in external disease and corneal surgery with Herbert E. Kaufman, MD at the University of Florida, Gainesville, beginning July 1. Upon completion of his fellowship he plans to join the Davis and Duehr Eye Clinic in Madison where he also will be associated with the Department of Ophthalmology at the University of Wisconsin on a part-time basis.

DR. HYNDIUK TO JOIN MEDICAL COLLEGE

Robert A. Hyndiuk, MD, a research fellow in the Department of Cornea Research, Retina Foundation, Boston, Mass., will join the faculty of the Medical College of Wisconsin July 1. Doctor Hyndiuk also is a clinical fellow, Cornea Service, Massachusetts Eye and Ear Infirmary, Harvard Medical School, Boston. After receiving a BS degree from Marquette University, Milwaukee, in 1958, he earned his MD degree from Loyola University, Chicago. In 1962–1963 and 1965–1967 Doctor Hyndiuk received special training in experimental extracorporeal dialysis and ophthalmology before becoming director of the External Disease Laboratory, University of Iowa Hospital, Iowa City, in 1967. From July 1969–June 1970 he was an NIH Special Fellow, Proctor Foundation, University of California Medical Center. From 1963 to 1965 he served as a lieutenant in the U.S. Navy.

DATES TO REMEMBER

Sept. 20–24: Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Convention Center, Las Vegas, Nev.

Oct. 23: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Lake Delton.

MADISON OPHTHALMOLOGIST DIES

Dr. James E. Dollard who practiced ophthalmology for many years in Madison died recently. His obituary appears in this issue on page 60.

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

NEWS HIGHLIGHTS

University Hospitals–Madison General Obstetrical Merger Started May 17

The Center for Health Sciences of the University of Wisconsin and Madison General Hospital completed the merger of their obstetrical inpatient facilities May 17, according to a joint statement issued by the two institutions.

All obstetrical patients under the care of University physicians are being delivered now at Madison General Hospital. The outpatient facilities at University Hospitals are continuing to serve as the office practice area for the University physicians, the statement said.

The consolidated Maternity–Neonatal Unit at Madison General Hospital will become a division of the Department of Gynecology and Obstetrics of the University of Wisconsin Center for Health Sciences. This consolidation achieves an important step in the establishment in Madison of a Regional Care Center for mothers and their newborn infants.

This unit in conjunction with the University's High Risk Neonatal Care Unit at St. Mary's Hospital Medical Center will serve as the care facility for high risk maternal and newborn patients in Madison and the surrounding region, according to the announcement.

The amalgamation of University and Madison General Hospital obstetrical services will facilitate improved patient care because of more economic use of highly skilled personnel and expensive and specialized facilities, the statement continued. As an example, the occupancy rate at Madison General has been approximately 65% with slightly more than 2,000 deliveries per year.

With a new total in excess of 2,600 deliveries per year resulting from this merger, the occupancy will rise to a more efficient 85%. This larger service will serve further as an improved base for the education of health professionals and provide an important resource for clinical and laboratory research directed toward the improvement of the health care of mothers and children.

The University administration and the Board of Regents of the University have reached a new and formal affiliation agreement with the Board of Trustees of Madison General Hospital making an even greater commitment to community-wide cooperation among health care institutions, the statement noted.

As the result of this move, a closer working relationship has been established not only between the physicians involved in the care of women and their babies but between nursing services and the schools of nursing at Madison General Hospital and the University, the statement concluded.

Dr. Waisbren Elected Member Critical Care Medicine Group

Burton Waisbren, MD,* director of the Burn Research Laboratory of St. Mary's Hospital Burn Center in Milwaukee, recently was elected a charter member and member of the Council of the Society of Critical Care Medicine at a meeting held in Los Angeles. Max Harry Weil, MD, professor of medicine, University of Southern California School of Medicine, is the first president of the Society, whose aim is to improve care for acute life-threatening illnesses and injuries, and to promote the development of optimal facilities for this purpose.

MDs Elected to WTRDA Offices

Benjamin G. Narodick, MD,* Milwaukee, recently was named president-elect of the Wisconsin Tuberculosis and Respiratory Disease Association at the annual meeting held in Milwaukee. Reelected to the board were MDs Helen A. Dickie,* Madison and Edward R. Loftus,* Winnebago. Oscar A. Sander, MD,* Milwaukee, was named to the association's senior council.

PHYSICIAN BRIEFS

Robert C. Feulner, MD*

. . . Waukesha, was honored recently for his outstanding work in medicine and for his contribution to radiology by being named a Fellow of the American College of Radiology. Dr. Feulner, who is affiliated with Waukesha Memorial and Milwaukee County General hospitals, is a 1953 graduate of New York University–Bellevue Medical Center.

John G. Beck, MD*

. . . Sturgeon Bay, recently received the first outstanding senior citizen award by the Sturgeon Bay Kiwanis Club. Doctor Beck has served as school, city, and county health officer since 1947. He also was co-chairman of the first United Fund drive.

Donald J. Ryan, MD*

. . . Neenah, recently was reelected president of Theda Clark Hospital medical staff in Neenah. Other officers are: MDs Paul E. Wainscott,* Menasha, vice-president; George B. Hildebrand,* Menasha, secretary; and Glenn E. Gustafson* and John R. Nebel,* Menasha, were elected delegates at large.

John A. Knights, MD*

. . . Superior radiologist, recently accepted the position of area medical director on the Board of Directors of the Wisconsin Division of the American Cancer Society whose state headquarters are in Madison.

Cesar V. Sison, MD

. . . and his wife, Aurora Sison, MD, recently opened their office in Kewaskum. The Doctors Sison are natives of the Philippines and also will practice in Campbellsport. Both the physicians are general practitioners with Doctor Cesar's specialty, surgery and Doctor Aurora's specialty, anesthesiology.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Arthritis Group Elects Officers

Mrs. Wyleen Alt, a nurse at Methodist Hospital, Madison, has been elected chairman of the newly formed Allied Health Professions Section of the Wisconsin Arthritis Foundation.

Other officers of the Wisconsin group are: vice-chairman, Paul Rasmussen, Madison District Office, Wisconsin Division of Vocational Rehabilitation; secretary, Miss Cyndy Brumund, a physical therapist at University Hospitals, Madison; and publicity chairman, Mrs. Cathryn Nastke, RN, of the Madison Visiting Nurse Service.

The Section has been organized by the Arthritis Foundation's Dane County Unit under the direction of Unit Chairman Mark N. Mueller, MD, assistant professor of Medicine, University of Wisconsin Medical School, and head of the arthritis clinic at University Hospitals.

The Wisconsin Allied Health Professions Section is one of the first local chapters formed in the nation. The National Arthritis Foundation formed an Allied Health Professions Section in 1965.

The Wisconsin Arthritis Foundation's Allied Health Professions Section has been organized to provide a forum for health professionals involved in the treatment of arthritis and rheumatic diseases.

By sharing information, it is hoped that the quality of care available to arthritic victims can be improved.

The organization plans to hold scientific meetings and seeks to stimulate rheumatic disease research relating to patient care among the allied health professions.

Membership in the group is open to nurses, nutritionists, physical therapists, occupational therapists, social workers, rehabilitation counselors, research associates, and psychologists.

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Burroughs Wellcome Grant Awarded to Med College

The Medical College of Wisconsin and a newly appointed professor of pharmacology, John C. McGiff, MD, are recipients of a $125,000 grant from the Burroughs Wellcome Fund, Research Triangle Park, N.C.

The award is to assist the College and Dr. McGiff in developing research and training in clinical pharmacology.

One of the founders of the Burroughs Wellcome Fund was Sir Henry S. Wellcome, one of the world's greatest figures in pharmacy and medicine, who was born in a log cabin at Almond, Wisconsin, near Stevens Point, in 1853.

Dr. McGiff, who will join the Medical College faculty in July, presently is professor of medicine and director of the cardiovascular section, St. Louis University School of Medicine.

Dr. Richard Reznichek Developing Residency Program in Viet Nam

Richard Reznichek, MD, son of Dr.* and Mrs. Cyrus G. Reznichek, Madison, has covered a tremendous expanse of medical territory in his young career. In 1963, during the spring quarter between his junior and senior years at Northwestern University Medical School, he went to Cambodia on a Smith Kline & French foreign fellowship. There he worked with a Medico hospital at Kratie and subsequently with another Medico installation in Maylasia.

In 1968, he was an AMA Volunteer Physician for Viet Nam and spent two months in the Mekong Delta at Rach Gia. This was followed by six weeks in Kuala Lumpur, Maylasia and another six weeks in Kabul, Afghanistan, both Medico projects.

Following his five-year residency at Harbor General Hospital in Torrance, Calif., and U.C.L.A., he joined the faculty at Duke University Medical School as assistant professor of urology. He is now in Saigon with the AMA Viet Nam Medical School Project for two years. There he is working with a counterpart to develop a residency training program in urology at the Saigon Medical School.

The senior Doctor Reznichek is the senior member of the East Madison Clinic. Young Doctor Reznichek graduated from the University of Wisconsin prior to attending Northwestern University Medical School.

Dr. Reznichek

Dane Arthritis Foundation Unit Reelects Dr. Mueller

Mark N. Mueller, MD of Madison, assistant professor of medicine at University Hospitals, recently was reelected chairman of the Dane County Arthritis Foundation Unit. Robert Bonebrake, MD* of Madison was elected vice-chairman. The Unit has been renamed the South Central District, Wisconsin Arthritis Foundation, and includes the counties of Dane, Sauk, Dodge, Columbia, Richland, Grant, Iowa, Lafayette, Green, Rock, and Jefferson.

Gundersen Clinic to Host Medical Clinics Meeting

Dr. Vernon Wilson, director of Health Services, Mental Health Administration, Department of Health, Education, and Welfare, is scheduled to address the North Central Regional Meeting of the American Association of Medical Clinics July 16–17 at the Holiday Inn in La Crosse. The AAMC North Central Region is comprised of 91 member clinics from nine states and Canada. They are: Wisconsin, Illinois, Indiana, Iowa, Michigan, Minnesota, Nebraska, North Dakota, South Dakota, and Canada.

Jack F. March, MD*

. . . Algoma, recently was notified that he has qualified for full fellowship status in the American College of Cardiology. He has specialized in heart disease since his graduation from medical school in 1950. He is a member of the American Heart Association, Wisconsin Heart Association, and the American College of Cardiology.

Conrad L. Andringa, MD*

. . . Madison, recently was selected by the American Academy of Pediatrics as Wisconsin consultant on a panel of 600 physicians to evaluate the medical aspects of Head Start programs in about 2,000 communities throughout the United States, Puerto Rico, Virgin Islands, and the Trust Territories of the Pacific.

John H. Morledge, MD*
Allen J. Pois, MD*

. . . members of the Jackson Clinic and the Methodist Hospital medical staffs, respectively, Madison, recently participated in the Great Lakes Health Congress held in Chicago. They presented a program titled "Modern Aspects of Medical and Surgical Heart Disease."

C. T. Clauson, MD*

. . . .Bloomer, recently received the distinguished service award from the Future Farmers of America in Bloomer. Doctor Clauson was president of the board of education for 12 years and has practiced medicine in Bloomer since 1928.

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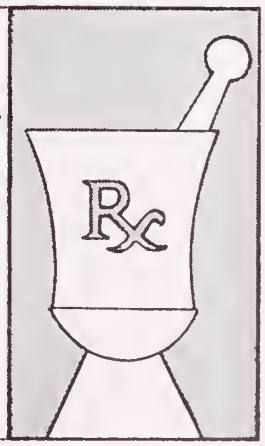

Leo R. Weinshel, MD*

. . . Shorewood, recently was selected for the 1971 Marquette University Alumni Service Award. A 1937 graduate of Marquette University School of Medicine, he is associate clinical professor of surgery at the school, now known as The Medical College of Wisconsin. Doctor Weinshel is a past member of the board of directors, officer and president of the Medical Alumni Association, and on numerous committees of the College. He is the senior attending surgeon and was chief of staff at Milwaukee County General Hospital, associate attending surgeon at Mount Sinai Hospital, visiting surgeon at Columbia Hospital and was senior attending surgeon at Milwaukee County Emergency Hospital.

Hania M. Ris, MD*

. . . Madison, was a member of the Task Force on Legal Rights and Justice which met recently during the White House Conference on Youth in Estes Park, Colo. Major topics considered by the Task Force included venereal disease, sex education, self consent for medical treatment, and whether to allow a pregnant girl to attend school. Doctor Ris is medical director of the Wisconsin School for Girls and is in the private practice of pediatrics and adolescent medicine as well as being on the clinical faculty in the Department of Pediatrics of the University of Wisconsin Medical School.

Glen M. Tucker, MD

. . . will be associated with William H. Frackelton, MD* and Jack L. Teasley, MD* Milwaukee in the practice of plastic and reconstructive surgery and surgery of the hand after July 1.

Anthony A. Herrmann, MD*

. . . Racine, recently became the director of medical services for S. C. Johnson & Son, Inc. He previously was medical director for General Motors' Delco Electronic Division at Oak Creek and served as a consulting physician for Western Publishing Co., Inc. and the Division of ESB, Inc. in Racine.

CONTRIBUTIONS—CES FOUNDATION

March 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for March 1971:

Nonrestricted

State Medical Society Members ---------Voluntary contributions of 521 MDs
Milton Finn, MD ----------Memorial: Victor Ekblad, MD
Dr. and Mrs. Leonard W. Schrank ------Memorial: Mr. Franklin Lentz
Earl R. Thayer, John M. Bell, MD ------Memorial: A. J. McCarey, MD
David N. Goldstein, MD ----------Memorial: James J. Lutz, MD
M. A. Christiansen, Mrs. Marcella Tomlinson, Mrs. Judy Adams, Frances H. Ryan, Mrs. Myrna Wichmann, Margaret K. Pharo, Wisconsin Physicians Service ---Memorial: Joe Poloni
Dr. and Mrs. Leonard W. Schrank, Dr. and Mrs. George A. Behnke, Mr. and Mrs. E. L. Jefferson, Earl R. Thayer, Dr. and Mrs. Donald A. Peterson, Dr. and Mrs. John K. Scott, Wisconsin Physicians Service ----------Memorial: Charles Stoops, MD
Vera K. Meyer, Margaret K. Pharo, James F. Miller, Jr. ----------Memorial: Charles Pollock
State Medical Society ----------Memorial: C. W. Crumpton, MD, W. P. Hamilton, MD, R. W. Juers, MD, Paul Kimmelsteil, MD, T. E. Lynn, MD

Museum of Medical Progress

State Medical Society Members ---------Voluntary contributions of 11 MDs
3M-Minnesota Mining & Mfg. Co., Motel Brisbois—Prairie du Chien, Wisconsin Power & Light Co., FS Services Inc., Oscar Mayer & Co., Peoples State Bank, Prairie Sand & Gravel Co., Inc. -------Ecology Exposition

Student Loans

State Medical Society Members ---------Voluntary contributions of 117 MDs
Smith, Kline & French Laboratories -----Contribution

Charitable—Disabled Physicians

State Medical Society Members ---------Voluntary contributions of 48 MDs

Scientific Teaching

State Medical Society Members ---------Voluntary contributions of 22 MDs

Other Than CESF Projects

State Medical Society Members ---------Voluntary contributions of 70 MDs

Wisconsin Academy of General Practice Loan Fund

State Medical Society Members ---------Voluntary contributions of 1 MD

Green County Student Loan Fund

State Medical Society Members ---------Voluntary contributions of 1 MD

Brown County Loan Fund

State Medical Society Members ---------Voluntary contributions of 2 MDs

Memorials

State Medical Society Members ---------Voluntary contributions of 2 MDs

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD ----------Contribution

Danforth Memorial Student Loan Fund

Mrs. Quincy Danforth ----------Contribution

Barbara Scott Maroney Memorial Fund for Research on Diabetes

Milton Finn, MD ----------Memorial: Barbara Scott Maroney

J. G. Crownhart Memorial Account

C. H. Crownhart ----------Memorial: Joseph Poloni, Charles Pollock

continued on next page

CONTRIBUTIONS—CES FOUNDATION *continued*

The Foundation wishes to acknowledge the following contributions for April 1971:

Nonrestricted

State Medical Society Members	Voluntary contributions of 421 MDs
L. O. Simenstad, MD, Manchesters, N. Alfred Hill, MD, Margaret E. Hatfield, MD	Contributions
Willard Hurst (Dining Club), Dane County Medical Society, E. J. Nordby, MD, State Medical Society, Jean Anderson	Memorial: J. E. Dollard, MD
Mr. & Mrs. David E. Beale, Earl R. Thayer, E. J. Nordby, MD, State Medical Society	Memorial: Karl H. Doege, MD
Eau Claire–Dunn–Pepin County Medical Auxiliary	Memorial: Curtis Griffith
Janice & David Reynolds, Earl R. Thayer, Mary Angell	Memorial: Mrs. Frieda L. Veenje
Wisconsin Medical Journal	Memorial: Charles Pollock
Dr. & Mrs. Gordon Schulz	Memorial: Mrs. Charles Haumersen
N. Alfred Hill, MD	Memorial: Dr. & Mrs. Richard E. Kelso, A. J. McCarey, MD
Dr. & Mrs. Thomas J. Doyle, Office Personnel—Board of Trade Bldg.	Memorial: Victor Ekblad, MD
State Medical Society	Memorial: E. A. Meili, MD, L. L. Sanford, MD, G. C. Matthews, MD, F. M. Frechette, MD

Museum of Medical Progress

State Medical Society Members	Voluntary contributions of 10 MDs
E. M. Dessloch, MD, Mrs. Joseph Marousek, Meyer Brothers—Dealers in Scrap Aluminum	Ecology Exposition

Student Loans

Holy Family Card Club	Memorial: John Jaeger
State Medical Society Members	Voluntary contributions of 116 MDs
Robert B. Murphy	Contribution

Charitable—Disabled Physicians

State Medical Society Members	Voluntary contributions of 45 MDs

Scientific Teaching

State Medical Society Members	Voluntary contributions of 13 MDs
Merck & Co. Inc.	Contribution

Tormey Memorial Fund

State Medical Society Members	Voluntary contribution of 1 MD

Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 46 MDs

Wisconsin Academy of General Practice Loan Fund

State Medical Society Members	Voluntary contribution of 1 MD

G. W. Hilliard Jr., MD, Fellowship Fund

State Medical Society Members	Voluntary contributions of 2 MDs

Memorials

State Medical Society Members	Voluntary contributions of 4 MDs

Barbara Scott Maroney Memorial Fund for Research on Diabetes

Woman's Auxiliary to the Sheboygan County Medical Society	Memorial: Barbara Scott Maroney

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

J. G. Crownhart Memorial Account

C. H. Crownhart	Memorial: Karl Doege, MD

State Surgeons Elect

New officers of the Wisconsin Surgical Society which met for its spring meeting in Milwaukee during the annual meeting of the State Medical Society, May 10–12, are: president, Ben R. Lawton, MD,* Marshfield; president-elect, Wayne Boulanger, MD,* Milwaukee; secretary–treasurer, Wilson Weisel, MD,* Milwaukee. Elected to the Council were Leonard Worman, MD* of Milwaukee and Edward Boldon, MD* of Madison.

Dr. Bruns Presents Paper on Cystic Fibrosis

A paper entitled "Polyvalent Heat-Killed Pseudomonas Vaccine in the Treatment of Cystic Fibrosis Patients," by B. A. Waisbren, MD,* W. T. Bruns, MD,* B. A. Brown, PhD, and T. A. Kurzynski, MS, Milwaukee, was presented by Doctor Bruns at the 12th annual meeting of the Cystic Fibrosis Club held in Atlantic City in April. This records a cooperative project between the St. Mary's Hospital Burn Research Laboratory, which is developing antiPseudomonas vaccines, and the cystic fibrosis group under Doctor Bruns at Milwaukee Children's Hospital.

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I. H. Bae, MD

. . . Anthony Marasigan, MD Hartford, recently joined the Hartford Clinic and the Parkview Medical Associates, respectively. Doctor Bae graduated from Kyungpook University in Taegu in 1963 and interned at Detroit Memorial Hospital. His residency was taken at Wayne State University School of Medicine. He served with the United States Government Health Service in the Virgin Islands before joining the Clinic. Doctor Marasigan graduated from Santo Tomas University, Manila, Philippines, and interned at St. Michael's Hospital, Milwaukee. He spent two years at St. Mary's Hospital, Milwaukee, and for the last three years has been associated with University Hospitals, Madison.

James L. Esswein, MD*

. . . Chetek, recently was elected to active membership in the American Academy of General Practice.

Andrew J. Krapohl, MD*
Richard M. Clifford, MD*

. . . Marinette and West Allis, respectively, recently were installed as fellows of the American College of Obstetricians and Gynecologists at its annual meeting in San Francisco.

Martin A. Rammer, Jr., MD*
Alois J. Sebesta, MD*

. . . Sheboygan and Shawano, respectively, recently were reelected to active membership in the American Academy of General Practice.

Wilfrido R. Yutuc, MD*

. . . La Crosse, recently returned to the Gundersen Clinic and La Crosse Lutheran Hospital after serving two years with the United States Army. He was awarded the Army's "Medal of Commendation" for meritorious service as well as the "Doughboy Award" for support of the Army's infantry school at Fort Benning. Doctor Yutuc has been associated with the Gundersen Clinic since 1962. □

Dr. T. O. Miller Elected Pres. NC Wis. Orthopedic Society

Thomas O. Miller, MD* of Wausau was elected president of the North Central Wisconsin Orthopedic Society at its April 24 meeting in Stevens Point.

Hosting the meeting was F. W. Reichardt, MD* of Stevens Point. Other members present were MDs C. A. Klasinski,* Stevens Point; T. O. Miller* and W. I. Norton* of Wausau; A. H. Khan, C. Mahalingappa,* and S. Bhattacharyya, Marshfield; W. E. Braun,* Merrill; and W. O. Dietsche,* Wisconsin Rapids. Wives also attended.

The Society's next meeting will be held in September with Doctor Dietsche as host. □

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF MAY 1971

3 Great Lakes Inter-Tribal Council
4 Madison Urological Society
4 Madison Anesthesiology Society
4 Dane County Medical Society Board of Trustees
6 Task Force to Bureau on Alcoholism, State Division of Mental Hygiene
8 Executive Committee of SMS Council (Milwaukee)
8 SMS Council (Milwaukee)
9 SMS Annual Meeting (Milwaukee)
9 SMS House of Delegates (Milwaukee)
10 SMS Annual Meeting (Milwaukee)
10 SMS House of Delegates (Milwaukee)
11 SMS Annual Meeting (Milwaukee)
11 SMS House of Delegates (Milwaukee)
12 SMS Annual Meeting (Milwaukee)
17 Dane County Medical Society Insurance Advisory Committee
17 Course on Management of Drug Abuse for Health Professionals
19 State Pharmacy Board Exams
24 Course on Management of Drug Abuse for Health Professionals
25 Course on Management of Drug Abuse for Health Professionals
27 Madison Academy of Internal Medicine

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Revised Diet Manual Available from State Nutrition Section

The third edition of the *Diet Manual for Small Hospitals and Nursing Homes* has been published by the Nutrition Section of the State Division of Health, Department of Health and Social Services.

Single copies of the 8½ x 11, spiral bound book are available at no charge to Wisconsin physicians upon request to the Nutrition Section, Box 309, Madison, Wisconsin 53701.

A number of sections included in previous editions have undergone significant changes or have been added to. They are: General Information; Diets for Older Persons; Diets for Pregnancy and Breast Feeding; Clear Liquid Diet; Full Liquid Diet; Semi-Soft Diet; Bland Diet I; Low Residue Diet; Calorie Restricted Diets; and Sodium Restricted Diets.

The Diet for Diabetes section includes a new Form for Meal Plan suggested as an alternate for purchase of the Meal Planning Booklet from the American Dietetic Association. This form and the lists of food exchanges can be used for patient instruction.

In addition, the Diabetic Liquid Diet has been revised and Adaptations of the Diabetic Diet has been added.

The Appendix includes the 1968 NRC Recommended Daily Allowances, Cholesterol Content of Some Foods, and a Revised Reference List, and the table of contents has a new "edge guide" for convenience in locating major topics.

As in the past, copies of diet sheets for patient instruction are available upon request for physicians' use. An order sheet is included in the back of the manual.

Revisions in the third edition of the manual have been largely an updating process, along with the addition of information requested by physicians, dietitians and personnel in hospitals and nursing homes who utilize the manual in preparing meals.

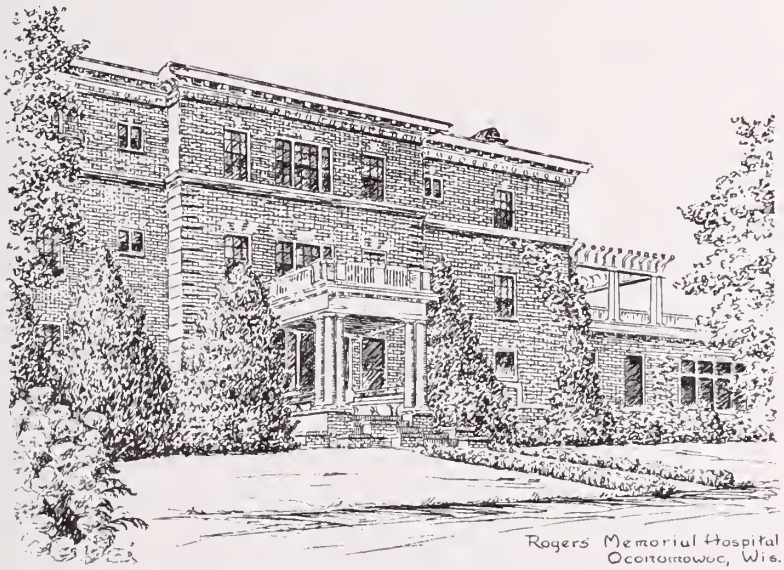
Dr. Ovid O. Meyer Surprised by Festschrift Honor

The *Wisconsin Medical Journal* in cooperation with the Wisconsin Medical Alumni Association completely surprised Dr. Ovid O. Meyer* May 21 during a meeting of the Alumni Association. Doctor Meyer, who retires June 30 after 40 years with the Department of Medicine at the University of Wisconsin Medical School, Madison, was presented the first copy of the *Journal's* May issue which contained a festschrift in his honor. Upon retirement Doctor Meyer becomes an emeritus professor. The festschrift included six scientific articles written by former residents who served under Doctor Meyer, as well as a historical article on the Department of Medicine by Dean Emeritus William S. Middleton, MD.* (A festschrift is a collection of "learned essays contributed by students, colleagues, and admirers to honor a scholar on a special anniversary.") Collaborating with the *Journal's* Medical Editor and Editorial Board were Dr. Robert F. Schilling, then president of the Wisconsin Medical Alumni Association and chairman of the Department of Medicine at the UW, and Dr. Donald R. Korst,* a former resident of Doctor Meyer and associate professor of medicine and director of medical education at Madison General Hospital. Doctor Meyer is the sixth person to be honored by the *Wisconsin Medical Journal's* festschrift issues. Others so honored are: Dr. William D. Stovall,* Madison; Dr. William S. Middleton,* Madison; Dr. Harry Beckman,* Milwaukee; Dr. Armand J. Quick,* Milwaukee; and Dr. Gunnar Gundersen,* La Crosse.

THE WISCONSIN MEDICAL JOURNAL'S medical editor, Dr. V. S. Falk of Edgerton, presented the first copy of the May festschrift issue to the honoree, Dr. Ovid O. Meyer, who was totally surprised and overwhelmingly pleased, during the May 21 meeting of the Wisconsin Medical Alumni Association. (Photo courtesy University of Wisconsin Medical School Information Office)

Family Practice Diplomates Named

Four Wisconsin physicians recently became diplomates of the American Board of Family Practice. They are: Burton K. Smith, MD* of the Wausau Clinic, Wausau, and MDs John Noble,* Roland Thurow,* and Richard Holder* of the Krohn Clinic in Black River Falls.



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OBITUARIES

Mabel F. Weissbrenner, MD, formerly of Chicago, Ill., died Mar. 2, 1971, in Madison.

Doctor Weissbrenner was a graduate of Rush Medical College, Chicago, and was a practicing physician in the Chicago area for many years. Her husband, Richard F. Weissbrenner, MD, died in 1963.

She was a member of the Chicago Medical Society, Illinois Medical Society, and American Medical Association.

Surviving are two daughters; Mrs. Kenneth G. Zweifel, Madison, and Mrs. Harold Dindinger, Chicago.

Emmett A. Meili, MD, 67, Cochrane, died Mar. 8, 1971, in Winona, Minn.

Born on Aug. 26, 1903, in Cochrane, Doctor Meili graduated from the University of Wisconsin Medical School in 1931, and served his internship at Kansas City General Hospital, Kansas City, Mo. Doctor Meili had served Cochrane and the surrounding area since 1932. He was the Buffalo County coroner for 18 years, and was the Cochrane health officer for several years.

He was a member of the Trempealeau–Jackson–Buffalo–County Medical Society, State Medical Society of Wissin, and American Medical Association.

Surviving are his widow and a brother, John R. Meili, Cochrane.

Victor J. Kozina, MD, 74, Wauwatosa, died Mar. 10, 1971, in Milwaukee.

Born on Aug. 15, 1896, in Stangelville, Wis., Doctor Kozina graduated from the Marquette University School of Medicine in 1941 and interned at St. Joseph's Hospital, Milwaukee.

Surviving are four sons, Dr. F. J., Brookfield; John, Washington, D.C.; Richard, Cedarburg; James, Racine; and a daughter, Mrs. Jerome (Ann) Pakenham, Louisville, Ky.

Leonard L. Sanford, MD, 75, Hillsboro, died Mar. 17, 1971, in Viroqua.

Born on May 11, 1895, in Richland County, Doctor Sanford graduated from the University of Wisconsin Medical School in 1936 and served his internship at Wisconsin General Hospital, (University Hospitals) Madison. His residency was taken at the Wisconsin Sanatorium and Muirdale. Doctor Sanford was for many years a special consultant to the United States Veterans Hospitals in Milwaukee, Des Moines, and Pittsburgh. He has been located in Hillsboro for the past 25 years and was active in community affairs.

He was a member of the Vernon County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Ruth; one son, Dr. Richard, Platteville; and two daughters, Mrs. Robert (Mary Ann) Morris, Mission, Kan., and Mrs. Kenneth (Kathryn) Kerst, Arlington, Va.

Harry A. Waisman, MD, 58, director of the Joseph P. Kennedy Jr. Memorial Laboratories at the University of Wisconsin, Madison, died Mar. 19, 1971, in Madison.

Born Apr. 25, 1912, in Milwaukee, Doctor Waisman graduated from the University of Wisconsin Medical School in 1947 and served his internship and residency at the University of Illinois Research and Educational Hospitals, Chicago. In 1952, Doctor Waisman joined the University of Wisconsin Medical School faculty as an associate professor of pediatrics and subsequently was named a full professor.

Both a physician and a biochemist, Doctor Waisman, along with the University of Wisconsin Primate laboratory staff, discovered the causes and a testing procedure for hereditary form of retardation known as phenylketonuria (PKU).

Surviving are his widow, Ethel; a daughter, Mrs. Karen Bloomberg, Chicago; and two sons, Donald, New York, and David, Madison.

Gilpin C. Matthews, MD, 40, Beloit, died Mar. 22, 1971, in Beloit.

Born on Sept. 25, 1930, in Beaufort, Mo., Doctor Matthews graduated from Washington University Medical School, St. Louis, Mo., in 1955 and served his internship at Letterman Army Hospital, San Francisco, Calif. He was a past president of the Beloit Visiting Nurses Association and a member of the American Academy of General Practice.

He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Jean, and three children.

Russell H. Miller, MD, 71, Whitewater, died Mar. 26, 1971, in Whitewater.

Born on July 17, 1899, in Whitewater, Doctor Miller graduated from Rush Medical College, Chicago, in 1923 and served his internship at Milwaukee County General Hospital.

Doctor Miller was a member of the Walworth County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; and a daughter, Mrs. Paul Cook, Lexington, Mass., and a son, William, Pittsburgh, Pa.

James E. Dollard, MD, 65, Madison, died Mar. 30, 1971, in Madison.

Born on Aug. 28, 1905, in Menasha, Doctor Dollard graduated from the University of Wisconsin Medical School in 1930 and served his internship at the Research Hospital, Kansas City, Mo. His residency in eye, ear, nose, and throat was taken at University Hospitals, Madison. Doctor Dollard served in the United States Army Air Corps from 1942–1946 during World War II.

He was a member of the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are a sister and three brothers.

Francis M. Frechette, MD, 67, prominent Janesville physician, died Apr. 4, 1971, in Janesville.

Born on Jan. 4, 1904, in Wisconsin Rapids, Doctor Frechette graduated from the University of Wisconsin Medical School in 1930 and served his internship at Norwegian American Hospital, Chicago, Ill. Doctor Frechette was associated with the Pember–Nuzum Clinic from 1931–1944 until opening a private practice in 1944. He was on the nursing school faculty of Mercy Hospital and was a member of the medical staff of the hospital. Doctor Frechette was a founding fellow of the American Association of Gynecologists and was a member of the Wisconsin Society of Obstetricians and Gynecologists.

A former president of the Rock County Medical Society, he also was a member of the State Medical Society of Wisconsin and American Medical Association.

Surviving are his widow, Sally; two daughters, Cindy and Kim, Janesville; and four sons, Dr. Paul, Madison; Peter, Wonder Lake, Ill.; John, Istanbul, Turkey; and Francis, Janesville.

Helen Jane Zillmer, MD, 77, Milwaukee, retired pediatrician, died Apr. 7, 1971, in Milwaukee.

Born on Feb. 23, 1894, in Milwaukee, Doctor Zillmer graduated from Johns Hopkins Medical School in 1920,

and served her internship and residency at Milwaukee Children's Hospital, and Woman's Medical College, in Philadelphia, respectively. She was a pediatrician for the New York State Department of Public Health in the early 1920s and did postgraduate studies on children's diseases in Vienna before returning to Milwaukee. Doctor Zillmer started private practice in 1935 and retired in 1969. She was given the Pro Urbe Medal Award by Mount Mary College, Milwaukee, for service to the community in 1969.

She was a member of the American Academy of Pediatrics, Milwaukee Pediatrics Society, Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

There are no immediate survivors.

Karl H. Doege, MD, 78, prominent Marshfield Clinic physician and former president of the State Medical Society of Wisconsin, died Apr. 12, 1971, in Punta Gorda, Fla.

Doctor Doege, son of the founder of the Marshfield Clinic, was considered the dean of the Marshfield medical fraternity and one of the city's most distinguished citizens.

Born Aug. 14, 1892, in Marshfield, Doctor Doege was educated in the Marshfield schools, the University of Wisconsin in Madison, and the Johns Hopkins University School of Medicine in Baltimore, graduating in 1917 with an MD degree.

His internship was served at Bay View Hospital, Baltimore, Md., after which he joined the Army Medical Corps as a first lieutenant in July 1918 during World War I.

He returned to the Marshfield community in 1919 to become the community's first qualified specialist in internal medicine at the Marshfield Clinic.

After his marriage in 1922 to the former Helen Ramsey, Doctor Doege, accompanied by his wife, spent 10 months studying in Vienna, Austria.

Doctor Doege returned to Marshfield to continue a career in medicine that "virtually spanned the history of the Marshfield Clinic." In November 1969 he celebrated 50 years of association with the Clinic, and on Dec. 1, 1970, officially retired.

At the time of the 50-year celebration, one of the guest speakers, Dr. William S. Middleton, dean emeritus of the University of Wisconsin Medical School, described Doctor Doege as "a rounded man in medicine," a friend of many years and a man of recognized integrity and high ideals.

Doctor Doege was president of the Marshfield Clinic staff from 1951–1956. His tenure came at a difficult time in the Clinic's history, but through his efforts he was credited with "stifling factionalism and uniting members in a program of giving"—"a program which meant considerable financial sacrifice to Doctor Doege and other older members of the institution." Today the Clinic is regarded as one of the Midwest's most outstanding medical facilities.

Certified by the American Board of Internal Medicine in 1937, Doctor Doege served as president of the Wisconsin Society of Internal Medicine in 1956. He also served as chief of staff of St. Joseph's Hospital in Marshfield.

Doctor Doege served as president of the Wood County Medical Society and was a delegate to the State Medical Society from Wood County for 10 years. He was medical editor of the *Wisconsin Medical Journal* from 1939–1948.

Doctor Doege and his father, Clinic founder Dr. Karl W. Doege, shared a unique honor—both served as president of the State Medical Society of Wisconsin, the father in 1922 and the son in 1948.

One of the outstanding services of Doctor Doege for the cause of medicine was his 15 years of service on the State Medical Society's Commission on Medical Care Plans, the Council committee that directs the activities of Wisconsin Physicians Service, the Blue Shield Plan of the State Medical Society. Doctor Doege was appointed to that directing board in 1949 and reappointed for successive terms until 1964. He also served on several other Society committees during his 50-year membership.

Doctor Doege was a member of the exclusive Wisconsin Heart Club, a preceptor of the University of Wisconsin Medical School, and a fellow of the American College of Physicians. He also belonged to the American Medical Association.

Doctor Doege was regarded not only as a physician but also as a citizen and over the years became identified with many worthwhile community enterprises.

(An editorial eulogy appeared in the May issue of the *Wisconsin Medical Journal.*)

Survivors include his widow, Helen; a son, Paul R. Doege of Minneapolis, Minn.; and a brother, Dr. Paul F. Doege of Tucson, Ariz. A daughter, Mrs. Thomas W. (Ruth) Stobbs, died May 28, 1965.

Robert Irving Hiller, MD, 71, former Milwaukee surgeon for 40 years, died Apr. 13, 1971, in Chicago, Ill.

Born on Aug. 25, 1899, in Ludington, Mich., Doctor Hiller graduated from the University of Pennsylvania Medical School in 1925 and served his internship at Michael Reese Hospital, Chicago. His residency was at Mount Sinai Hospital, New York City.

Doctor Hiller retired from practice in 1963 and moved to Israel to do cancer research and teach at Hebrew University. During World War II he served as a major in the Army Medical Corps.

Surviving are his widow, Trudy; two daughters, Mrs. Robert Levy, Madison, and Mrs. Harvey Schneider, Chicago.

Ernest Clyde Howell, MD, 82, Fennimore physician for 60 years, died Apr. 26, 1971, in Dubuque, Ia.

Born on Jan. 12, 1889, in Mt. Ida Township, Doctor Howell graduated from the Marquette University School of Medicine in 1911. He served in the United States Army during World War I and on his release from active duty, he was in the Army Medical Corps Reserve. He had been a member of the Lancaster Memorial Hospital medical staff since 1955 and in 1964 was elected chief of staff.

Doctor Howell was a past president of the Grant County Medical Society, a member of the Committee on Cancer of the State Medical Society of Wisconsin, and a member of the American Medical Association.

Surviving are his widow, Flosse; and a son, Dr. David A., of Dubuque, Ia.; and a daughter, Mrs. F. J. Vossler, of Findlay, Ohio. □

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DEATHS

Kozina, Victor J., non-member, Mar. 10, 1971
Zillmer, Helen J., Milwaukee County, Apr. 7, 1971
Hiller, Robert Irving, non-member, Apr. 13, 1971
Harper, Charles W., Milwaukee County, Apr. 14, 1971
Kampine, Clifford E., Marathon County, Apr. 23, 1971
Howell, Ernest C., Grant County, Apr. 26, 1971
Hoesley, Henry F., Lafayette County, May 1, 1971
May, Joseph H., Manitowoc County, May 6, 1971
Robb, James J., Brown County, May 10, 1971 □

BOOKSHELF

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CARDIAC ARREST AND RESUSCITATION

By Hugh E. Stephenson, Jr., MD, Professor of Surgery, University of Missouri School of Medicine, Columbia, Mo. The C. V. Mosby Co., Saint Louis, Mo. 1969. 659 pages. Price: $29.50

This volume presents a comprehensive survey of the literature of the diagnosis and treatment of cardiac arrest and resuscitation. It is the composite effort of 18 authors, most of whom have been in the forefront of research and treatment in the area of resuscitation. The contents include an historical survey or reanimation, mechanisms of cardiac arrest and methods of diagnosis, and an extensive review of techniques for cardiopulmonary resuscitation as practiced in the surgery, coronary care unit, physician's office and at public gatherings.

There is an extensive discussion of the pitfalls and complications of cardiac resuscitation with a review of the physiological mechanisms responsible for them. The extensive and well-written volume must be considered a source reference for workers in the field of heart disease; more particularly, cardiologists and cardiac surgeons will find it useful. The book will also be an excellent source material for those who have responsibility for instruction and teaching in the area of cardiopulmonary resuscitation.

The bibliography is extensive. In most instances, the illustrations are quite helpful and there are many tables, e.g., the medications currently used in resuscitation attempts. This book may prove useful to cardiologists and cardiac surgeons, especially those who are actively engaged in research in the area of cardiac arrest and resuscitation. It should also be a part of the general hospital reference library.—DONALD A. SPRING, MD

WINE AND THE DIGESTIVE SYSTEM

By Salvatore Pablo Lucia, MD. Fortune House, San Francisco. 1970. 157 pages. Price: $3.50

This is one of several books on wine and medicine written by the author. This book is essentially an annotated bibliography of all articles relating alcohol and the digestive system from Hippocrates to the 1969 *Medical World News* report of a Texas symposium. The book is not suitable for leisurely reading because only a few sentences are given about each publication. The book would be primarily of value for someone who wished to find a few historical references to flavor up an article on alcohol. The book is well adapted to this use. Most of what is written under each article is a direct quotation from the original reference.—JOHN F. MORRISSEY, MD □

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1971 WISCONSIN

Aug. 5–28: Scandinavian/Russian Holiday, Wisconsin Alumni Association. Info: Wisconsin Alumni Tours, 650 N. Lake St., Madison, Wis. 53706.

Aug. 25–28: *Emergency Care and Transportation of the Sick and Injured,* Wisconsin Center, Madison. Chrm. K. M. Sachtjen, MD, 2704 Marshall Court, Madison 53705. Sponsored by American Academy of Orthopaedic Surgeons. Info: American Academy of Orthopaedic Surgeons, 430 North Michigan Ave., Chicago, Ill. 60611.

Sept. 10–11: Annual scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel and Tower, Milwaukee.

Sept. 17–18: Fall Meeting, Wisconsin Society of Internal Medicine, Green Bay. Program Chairman: John M. Irvin, MD, Monroe. On Sept. 17, Dr. Paul Lacy—Mallinckrodt Professor of Pathology at Washington University, St. Louis, Mo.—will speak on Beta Cell Secretion.

Sept. 17–18: Annual Fall Meeting, Wisconsin Society of Internal Medicine, The Forum, Green Bay.

Sept. 17–19: Annual Fall Meeting, Wisconsin Surgical Society, The Abbey, Fontana (Lake Geneva).

Sept. 17–19: Annual Meeting, Wisconsin Radiological Society, Kahler's Inn Towne Motel, Wisconsin Dells.

Sept. 18–19: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Sept. 22: Sixth annual Adolf Gundersen Symposium for Physicians—"Understanding Arrhythmias." Co-sponsored by the Wisconsin Heart Association and the Adolf Gundersen Foundation. Valhalla Hall, Wisconsin State University, La Crosse.

Sept. 24–25: Annual Meeting, Wisconsin Academy of Pediatrics, University of Wisconsin Center, Madison.

Sept. 30–Oct. 2: District VI Meeting of American College of Obstetricians and Gynecologists and Nurses Conferences, Loraine Hotel & Park Motor Inn, Madison.

Oct. 15–16: Annual Fall Meeting, Wisconsin Society of Obstetrics and Gynecology, The Abbey, Fontana (Lake Geneva).

Oct. 16: Seventeenth Annual Fall Cancer Conference (scrimmage), Division of Clinical Oncology, University of Wisconsin Medical Center, Madison and Wis. Division of American Cancer Society. Info: Robert J. Samp, MD, University Hospitals, Madison, Wis. 53706.

Oct. 17–23: Wisconsin Work Week of Health.

Oct. 30: Wisconsin Dermatological Society, Wood Veterans Administration Hospital, Milwaukee.

1971 NEIGHBORING STATES

Sept. 13.–15: *Clinical Electroencephalography.* American Electroencelphalographic Society, in Minneapolis, Minn. Info: Donald W. Klass, MD, EEG Course Dir., Mayo Clinic, Rochester, Minn. 55901.

Sept. 13–18: American Electroencephalographic Society and the American Society of EEG Technologist (ASET) Annual Meetings, Hotel Radisson South, Bloomington, Minn. Info: Mrs. Margaret H. Henry, Exec. Secy., The American EEG Society, 36391 Maple Grove Rd., Willoughby Hills, Ohio 44094.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Oct. 4–9: Postgraduate course in Laryngology and Broncho esophagology, Department of Otolaryngology of the University of Illinois at the Medical Center, University of Illinois Eye and Ear Infirmary, Chicago, Ill.

Oct. 10: Joint scientific meeting, American College of Preventive Medicine and Association of Teachers of Preventive Medicine, Hotel Leamington, Minneapolis, Minn.

Oct. 16–21: American Academy of Pediatrics 40th Annual Meeting, Palmer House Hotel, Chicago, Ill. Info: Department of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

Oct. 23–29: Annual Otolaryngologic Assembly of 1971, University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill.

Oct. 28–30: *Antibiotics and Infection Course,* University of Iowa, Iowa City.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

1971 OTHERS

Aug. 18–22: *Fourteenth Annual UCLA Advanced Seminar on Internal Medicine,* UCLA Extension and UCLA School of Medicine, University's Residential Conference Center, Lake Arrowhead. Info: Donald Brayton, MD, Director, Dept. of Continuing Education in Health Sciences, Room 15–39 Rehab. Center, Univ. Exten., UCLA, Los Angeles, Calif. 90024; or tel. Kathleen Blake at (213) 825–7257.

Sept. 6–10: *Organ Failure—Lung, Heart, Kidney, Blood, Liver,* American College of Physicians and Royal College of Physicians and Surgeons of Canada, Dalhousie University Faculty of Medicine, Halifax, Novia Scotia. Credit of 28 hours allowed toward AMA "Physician's Recognition Award." Info: Registrar, Postgraduate Courses, ACP, 4200 Pine St., Philadelphia, Pa. 19104.

Sept. 20–24: American Academy of Ophthalmology and Otolaryngology Annual Meeting, Convention Center, Las Vegas, Nev. Info: C. M. Kos, MD, Exec. Sec.–Treas., American Academy of Ophthalmology and Otolaryngology, 15 Second St., S. W., Rochester, Minn. 55901.

Sept. 27–Oct. 1: *Hospital Medical Staff Conference,* University of Colorado School of Medicine, Estes Park.

Sept. 30–Oct. 2: Postgraduate course on *Pediatric Cardiorespiratory Care,* Houston, Tex. Info: Dept. of Continuing Education, American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Oct. 5–7: *18th Spinal Cord Injury Conference.* Joint meeting of Veterans Administration Department of Medicine and Surgery and International Medical Society of Paraplegia, Children's Hospital Medical Center, Boston, Mass.

Oct. 8–9: Department of Otolaryngology, University of Miami School of Medicine, *Postgraduate Course in Otolaryngology,* Miami, Fla., Sheraton Four Ambassador Hotel. Info: F. W. Pullen, II, MD, Neuro-Otologic Laboratory, School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Oct. 11–13: Obstetrics and Gynecology Postgraduate Medical Education, Denver, Colo. Info: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Oct. 20–22: 18th Western Cardiac Conference, University of Colorado Medical Center, Denison Auditorium, Denver. Info: Colorado Heart Assn., 1375 Delaware St., Denver, Colo. 80204.

Oct. 23: American Gastroenterological Association Regional Postgraduate Day at three locations: Pittsburgh, Pa., San Antonio, Tex., and Portland, Ore. Info: Mrs. Francis T. Chalmers, AGA Postgraduate Courses, Box 190, McLean, Va. 22101.

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Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
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Nov. 8–12: Course in *Occupational Health for Nurses,* Department of Environmental Medicine of New York University School of Medicine in cooperation with American Association of Industrial Nurses. Tuition: $175. Course No. 484. Applications to: Office of Recorder, N. Y. U. Post-Grad. Medical School, 550 First Avenue, New York, N. Y. 10016.

Nov. 9–10: Annual Scientific Meeting, Council on Arteriosclerosis of the American Heart Association, Anaheim, Calif.

Nov. 11–14: 44th Annual Scientific Sessions, American Heart Association, Convention Center, Anaheim, Calif.

Nov. 15–19: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, P. O. Box 5445, Madison, Wis. 53705)

Understanding Arrhythmias—La Crosse Symposium

The Fall Symposium of the Adolf Gundersen Medical Foundation is scheduled for September 22 at Wisconsin State University in La Crosse. Entitled, "Understanding Arrhythmias," the program will begin at 9 a.m. and will last until about 4 p.m. in the same format as previous years.

Registration fee is $15 which includes the printed Proceedings of the Symposium which will be mailed following the Symposium to all registrants.

The five speakers this year, in the order in which they will appear on the program, are:

Emanuel Stein, MD: Chief, Clinical Cardiology, and Chief, Medical Education at the U. S. Public Health Service Hospital, Staten Island, N.Y. Recently his work on the use of intracardiac electrodes to analyze complex arrhythmias has received the attention and interest of his colleagues in cardiology. Title of his talk: *Cardiac Electrophysiology.*

Richard Langendorf, MD: Professorial Lecturer in Cardiology, University of Chicago; Research Associate, The Cardiovascular Institute; Senior Attending Physician, Department of Medicine, Michael Reese Hospital, Chicago, Ill. In 1948 Doctor Langendorf introduced into clinical electrocardiography the concept of "concealed conduction" which has proved essential for the interpretation of many arrhythmias and has recently been confirmed by direct recordings from the conduction system. Title: *The Differential Diagnosis of Supraventricular and Ventricular Arrhythmias.*

Mauricio B. Rosenbaum, MD: Chief, Service of Cardiology, Salaberry Hospital, Buenos Aires, Argentina. Doctor Rosenbaum is widely recognized over the world as one of the few original thinkers and great teachers in electrocardiology. Title: *Heart Block Below the AV Node.*

Jan Koch-Weser, MD: Associate Professor of Pharmacology, Harvard Medical School; Associate Physician, Massachusetts General Hospital. Doctor Koch-Weser has had a particular interest in the anti-arrhythmic agents. Title: *Anti-Arrhythmic Agents—The Relation of Their Fate and Actions in Man.*

Seymour Furman, MD: Assistant Professor of Surgery, Department of Surgery, Albert Einstein College of Medicine, Yeshiva University, New York, N. Y.; Associate Attending, Department of Surgery, Montefiore Hospital and Medical Center, Bronx, N. Y. Doctor Furman is widely credited with being the first to use a catheter electrode for cardiac pacemaking. Program planners say there is no one who is better equipped through personal experience to talk on the many and varied problems of modern electronic pacemaking. Title: *The Indications for Electronic Cardiac Pacemakers and Some of the Problems of Pacemaking.*

Info: A. Erik Gundersen, MD, Program Chairman, Adolf Gundersen Medical Foundation, La Crosse, Wis. □

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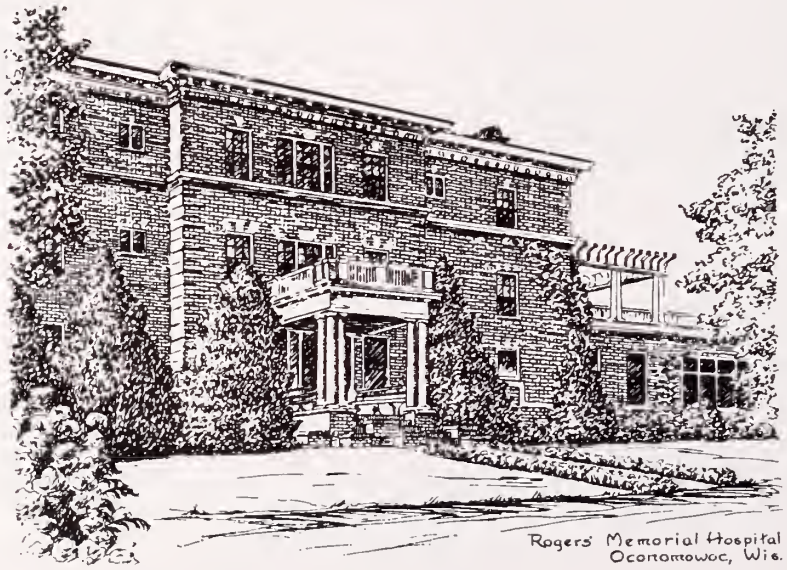

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Yutuc, Wilfrido R., 333 North 23rd St., La Crosse 54601

DEATHS

Healy, William G., Rock County, May 23, 1971
Banner, Bernard R., nonmember, June 8, 1971
Fox, James C., La Crosse County, June 12, 1971 □

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Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

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The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

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Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

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Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

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PRESIDENT'S PAGE

Open Invitation to Direct Line Communication

LACK OF COMMUNICATION—this is a phrase we have been hearing frequently in the last few years. It is the excuse young people use to express their differences in philosophy from the adult generation. It is also a phrase that accounts for many of the differences between the State Medical Society and its members.

What is communication? It should be a dialog that is a flow of information back and forth between the parties concerned. I realize that at times the State Society has not always been able to fulfill its obligation in this respect, but every effort is being made to correct this. Even more lacking has been the efforts of members to communicate their ideas and desires to the Society. Your Delegates and Councilors do have a direct line to the Society and your State Officers are always willing to hear and discuss your ideas.

Very shortly a letter will be sent to each County Society President, offering an AMA Delegate and a State Officer as speakers at your local Society meeting. I sincerely hope your County Society will make use of these men for personal dialog about the State Society and the AMA.

Realizing that it is impossible to represent every diverse opinion, I feel that if we can each be better informed and knowledgeable about the problems facing medicine, then our ideas may not be as divergent as we had thought; and if they do differ, then at least we have a better understanding of the other person's reasons for his opinion. As an example: WPS has borne the brunt of criticism on Medicare and Medicaid payments. However, WPS and the Commission on Medical Care Plans have done their utmost to present the views of the doctors, but in the final analysis, as carrier, WPS implementation of Medicare–Medicaid is dominated by government regulations that are mandatory. The only way WPS can do otherwise would be to relinquish its role as Medicare and Medicaid carrier and let some other carrier administer these functions. You can be assured that some other carrier may not be as concerned about either your welfare or the patients'.

Future issues of the President's Page will be dedicated to matters that I hope will be of direct concern to every member. I would welcome suggestions from members on what subjects are of interest and will try to use this page to answer your questions. Let's make this a dialog so we can end this lack of communication.

G. A. Behnke M.D.

G. A. BEHNKE, MD

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Howard Mauthe, MD_____Fond du Lac
R. F. Lewis, MD_____Marshfield
R. D. Heinen, MD_____Oconto Falls
W. R. Manz, MD_____Eau Claire
T. J. Doyle, MD_____Superior
T. J. Foley, MD_____Milwaukee
W. J. Egan, MD_____Milwaukee
DeLore Williams, MD_____West Allis
D. K. Schmidt, MD_____Milwaukee
R. B. Pittelkow, MD_____Milwaukee
E. P. Rohde, MD_____Galesville
W. W. Meyer, MD_____Medford
M. F. Huth, MD_____Baraboo

EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

The Shape of Things to Come

AMERICAN MEDICINE stands at a crossroad. We have mostly travelled the Calvinistic path. This refers not to religious concepts but to methods of practice. Success in delivery of medical services has until recently been measured by such values as personal providence, sustained hard work, individual management and risk, and some sort of militant self-sufficiency. Those of us who have practiced within these puristic guidelines are sometimes unaware of the real changes that soon will be required of us. Certainly I find it hard to accept the fact that my practice will ever be any different, no matter what flows around me.

Yet, for example, methods of payment for medical service have changed in just a few short years. Third party payment, either private or public, is intruding—even into the most private of private practices. New schemes would support only those practitioners who abandon their traditional role for group practice and group payment. Some have converted already; others are seriously studying the new pattern. Private practice also means privacy. That too has changed with peer review committees, utilization surveys by colleagues, and public accountability just getting underway. While there is some comfort in being "certified" by members of our own hospital staff, two uncertainties crowd for attention from this very new fact. One is that implied in the process of judgment of one's fellows. "Those who command the respect of the entire staff" sounds sterling, yet could slip into a political morass. A second concern implied in such judgment is the further extension, most logically of course, to judgment by larger units, medical societies, state boards of health, United States Public Health Service, and perhaps by some element of a 'national crash program for cancer.' Once the judging slips past the focus of patient and physician, it can land in any or all of these places. All are outside the personal contract.

A third major change, intrinsic with the first two mentioned, is in regard to the role played by physicians. For centuries we have been the sole repository of decision about health matters. Even the USPHS has been physician run. Now there are intrusions by federal, state and county governmental units, by private groups who have medical judgments about megavitamines and other disease oriented problems, and by consumer groups, both radical and conservative. The doctor is fast fading into one of many faces clamoring for services, and demanding one form or another of such services. At the crude level, the curious and deadly gamble with life indulged in by the legislature of Wisconsin, over chiropractic, illustrates the range of political decision over matters we used to consider life and death—to be within our province. At more sophisticated levels there are infinitely more decisions each year that start not with physicians, but with public agencies, even welfare groups.

Extremes are always fearful. Some physicians predict the Doom of Orwell's 1984, with mechanical and stylized practice of medicine. Others sit on our mushroom and fantasy a consumers rebellion that will force individual private practice back to dominance. Probably neither of these will happen. The terribly complex interpoints between these two extremes will evolve within the next five years at most. What part physicians can and want to take will depend somewhat upon how aware they are of the changes demanded, of the political quicksilver upon which these changes will occur, and lastly upon their self-awareness of those facets of what may be called generally middle class values, which may well interfere with becoming an orderly part of change. Without such knowledge the chance of becoming a victim of change, rather than part of it, is much greater. In the months to come this column will be dedicated to exploring these and other new developments. To fail to explore what is happening about us seems folly. It seems a fair charge to a new editorial director that he contribute to the clarity about our past, our present and our future. I accept this challenge.

—RH

Estriol Determinations in High-Risk Pregnancies

Doctors Curet, Carlson and Farb are to be complimented on the continued use of and attempts to improve upon the fundamental observations of B. Zondek and S. Goldberg[1] and J. W. Greene, Jr.[2] Estriol determinations have gained importance in monitoring the high-risk pregnancy. Their greatest value will be attained when reliable and reproducible methods are available to the clinicians. The authors' results point to the high-risk problems with which they dealt and probably, as one of the editors of the Obstetrical and Gynecological Survey indicated, that maximum reliability has not yet been attained in all testing. It is essential that clinical judgment, not a laboratory test alone, be the directing force.

In the series reported, the fetus was dead in four instances, practically dead with an Apgar of 1 in another four instances and only eight, 50%, were alive with reasonable Apgar ratings. The authors realize the shortcomings, the need for further investigation and the need for additional methods of monitoring.

Obstetrics in America has become a complex study of contradictions and contrasts. Emphasis on one hand is on the natural status of the gestational period which should end in the natural process of birth practically unaided by the accoucheur. In fact, his only use is recognized by some as being available to lend moral support, assist in the delivery of the placenta, and in immediately placing the newborn infant to the new mother's breast. The prospects of this type of monotonous professional existence combined with the prospects of many of these natural events occurring at night, on holidays or on weekends have disenchanted many from entering this discipline. Practiced in moderation, there is value in this attitude for an informed patient will have no fear. She will need less medication and, without obstetrical complications, the result will be a healthy infant and mother.

Obstetrics, in fact, is never this simple or monotonous. Obstetrics is coming of age. With awareness of the high-risk pregnancy, it is presenting the challenge that youth is seeking.

Gestational detection of the high-risk pregnancy has become a necessity not only based upon genuine concern for maternal and fetal outcome but also to guard against the ultimate legal liability that surrounds the obstetrician for 23 years from the day of delivery. The day is at hand when the pregnant diabetic, the cardiac, the grand multigravida, the nutritionally deficient, the very young, the very old, the repeat aborter, the patient destined to repeat premarital offspring, and the severe toxemic patient must have special attention. To meet this challenge, medicine can take two directions. The first is to establish High-Risk Centers so located that they are easily accessible by air transportation and expressways. The second is the centralization of obstetrical units adequately equipped and staffed so that a significant census of obstetrical patients can be maintained to use the supplemental specialized facilities. This means concentration of obstetrical patients. The basis for these specialized units which will care for the high-risk pregnancy, in the antepartum period, the labor and delivery and the postpartum periods, will be within arms length proximity of High-Risk Obstetrical and High-Risk Nursery areas staffed by specially trained, compassionate personnel. The specialized obstetrical nurse assistant and the pediatric nurse assistant must, like the specialized nurse in cardiac care who can defibrillate a patient, be able to cope with emergencies as they develop. The assistant must always be under expert medical direction.

The obstetrical unit must have electronic monitoring, modern ultrasonic equipment must be available, radioisotopic scanning equipment is a necessity, and modern laboratories with interested biochemists able to provide enzyme chemistry and gas analytical procedures are essential.

All this highly technical help, specialized manpower and scientific equipment also has the tendency to turn the medical student away. Students want patient contact. It is necessary to understand that both the natural concept and the highly scien-

[1] *J. Obst. & Gynaec.*, Brit. Emp. 64:1–13 (Feb) 1957.
[2] *Am. J. Obst. & Gynec.* 85:1–9 (Jan 1) 1963.

tific concept are essential so that adequate methods can be developed and made available through cooperative efforts to the clinician who is in body contact with the patient. Many of these methods are still controversial and refinements and changes are necessary. The last word has not been spoken in the use of and dependency upon estriol levels.

What is essential is that obstetrical care will be in the hands of well trained and highly motivated men and women who through auscultation and palpation can and will clinically monitor a patient from the first antepartum visit through the postpartum period. Obstetricians and associated personnel will recognize the clinical aspects and hazards of bleeding, the Type 2 fetal heart dip, the threat of prematurity, and the dangers of delayed respiration. These concerned professionals will be stimulated by adequate training to spring to action and use the available technical assistance for the welfare of the patients. —FREDERICK J. HOFMEISTER, MD, Wauwatosa □

MINUTES OF COUNCIL MEETING

MADISON, MARCH 27–28, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:00 p.m. on Saturday, March 27, 1971, at the State Medical Society.

Voting members present: Doctors Huth, Davenport, Nordby, Edwards, Dettmann, Mauthe, Rohde, Boren, Ludwig, Manz, Doyle, Chojnacki, Hollenbeck, Foley, Schmidt, Egan, Past President Callan, and Speaker Nereim.

Officers and others present: President-elect Behnke; Vice-speaker Hamlin; AMA delegates Bell, Galasinski, Hildebrand, Picard; alternate delegates Carlson, Twelmeyer, Russell, Kief; Doctors Simenstad and Tormey; Messrs. Thayer, Koenig, Reynolds, Brower, Maroney, LaBissoniere, Johnson, Crownhart, Gill, Murphy, Kluwin; Mrs. Anderson and Miss Pyre.

2. Approval of Minutes of November 14, 1970

On motion of Doctors Chojnacki–Hollenbeck, carried, these minutes were approved as circulated, with addition of an item omitted from the report of the Executive Committee concerning the Past Presidents Committee.

3. Creation of Section on Plastic Surgery

On motion of Doctors Egan–Boren, carried, the Council approved the recommendation of the Executive Committee that the request for creation of a scientific section for plastic surgery be forwarded to the House of Delegates for approval, along with a recommendation that the House refer to a committee for re-examination the whole question of delegate representation with voting privileges for segments other than county societies.

4. Resolution of Appreciation to T. W. Tormey, Jr., M.D.

On motion of Doctors Ludwig–Schmidt, carried, the Council adopted the following resolution:

RESOLVED, That the Council of the State Medical Society of Wisconsin express to T. W. Tormey, Jr., M. D., Madison, its great appreciation for his inspiring and dedicated efforts in acquiring and displaying a collection of medallions depicting men and moments of significance in medical history. Thank you, Doctor Tormey, for bringing this proud recognition of medicine's heritage to the attention of the profession and the public.

5. Commission on Hospital Relations and Medical Education

The Executive Committee had referred to the Council a recommendation initiated by Mr. Crownhart as Secretary that the name and function of this Commission be changed, by amending the bylaws, to the "Commission on Medical and Related Education." It was proposed that hospital relations problems be handled by the Council or its committees, inasmuch as liaison with the Wisconsin Hospital Association in recent years has been through joint meetings of its Executive Committee and the Executive Committee of the Council.

Doctors Chojnacki–Mauthe moved the recommendation which was defeated after discussion. It was agreed that the present arrangement be continued for another year, with any urgent matter brought to the attention of the Executive Committee, and projects requiring further study referred to the existing Commission.

6. Standard Casualty Medical Report Form

On motion of Doctor Edwards, seconded and carried, the Council approved a revision of this form originally endorsed by the Society several years ago.

7. Life Membership

The Council accepted the recommendation of the Executive Committee that no attempt be made to re-establish a "buy in" provision for life membership as had been suggested, and that the present requirements be maintained.

8. Commission on Public Policy

A. Position Paper

The GREEN SHEET from the March *Wisconsin Medical Journal* was distributed to the Council. It consisted of a policy statement on major public health and medical issues and a listing of key bills and their status. This will be updated as the report of the Commission to the House of Delegates.

B. Podiatry

Doctor Russell reported that podiatrists are seeking legislative authorization to dispense narcotics and to amputate toes. The Commission intends to review the current position of the Society of opposition to such extension of podiatric practice with the Section on Orthopedics.

C. Certificate of Need Legislation

Mr. Murphy reviewed the purpose of legislation proposed by the Advisory Council for Comprehensive Health Planning which had been reported to the Council in November and opposed at that time inasmuch as services were included with health care facilities being subject to approval and issuance of a certificate of need.

Doctor Kief reported that the Board of Health and Social Services had discussed the proposed bill that week and had voted to request elimination of reference to services of physicians. The bill is to be reviewed again by the Board before introduction.

On motion of Doctors Chojnacki–Ludwig, carried, the Council reiterated its opposition to inclusion of professional services in certificate of need legislation.

9. Report of Finance Committee

Doctor Dettmann, chairman, presented the following report:

A. 1971 SMS Operating Budget

The committee met on two separate occasions to consider and develop a proposed 1971 Operating Budget, based on review of 1970 performance. The committee and staff made a special effort to propose a realistic but conservative budget, and wished to emphasize the following areas of consideration.

One was the proposed elimination of the Workmen's Compensation Open Panel project which it was felt no longer carries a value in proportion to the costs involved. The committee also recommended the elimination of any Society cost for holding district caucuses. Other special budgetary provision items have been integrated with the appropriate regular budget items.

Another was the suggestion of Council Chairman Nordby to encourage Society committees to select additional officers, including a vice-chairman and a secretary, and that these officers take a more direct and active role in the preparation of agendas and minutes, to cut down on staff participation.

Other important considerations were:

(1) Reduction in payroll and related costs.

(2) Slight increase in staff travel costs in anticipation of fulfilling the Council's recommendation that each county medical society be visited this year by the Secretary and the Insurance Director.

(3) Reduction in the Office Supplies expense, part of an effort to hold down costs.

(4) Reduction in general insurance costs based on 1970 experience.

(5) Reduction in the Cafeteria Account, based on 1970 experience.

(6) Outside Services involve public relations consultation and related activities, and this item has been decreased based on anticipation of a new full-time employee to administer these activities internally.

(7) Legal Counsel. Efforts will be made to reduce general legal costs by requiring the attendance of counsel only at meetings, or portions of them, as required. Attempts will also be made to utilize legal talents of staff members on some of the more routine or less specialized problems. However, the total amount budgeted for legal costs is increased due to the initiation of the Professional Liability Consultation Service which Mr. Kluwin is handling.

(8) Contingency Fund Account. It was proposed that this figure be increased from $5,000 to $10,000, to reflect a more realistic cost. However, the committee and staff felt that controls should be effected for contingency items, and the committee recommended that the Council approve the higher amount, at the same time retaining its control of the funds.

(9) PACE. The committee recommended that contributions to PACE for educational purposes be eliminated from the Operating Budget as soon as current obligations have been met, and emphasized its view that physicians should be encouraged to support and participate in PACE on an individual basis.

The committee also reviewed the Society's costs with respect to funds used for the Woman's Auxiliary, which amounts to approximately $20,500. In the interest of some economies, particularly in their annual meeting expenses, the Finance Committee recommended that the Advisory Committee, composed of the officers of the Society, meet with the Auxiliary and bring back to the Council a report of its discussions.

An item of increased budget is that of expenses for AMA Delegates and Alternate Delegates, who had requested consideration of increasing their meeting expense advances because transportation costs use up much of the current payment of $500 for each meeting, particularly when meetings are held in locations other than Chicago. The committee felt this was a reasonable request and recommended the additional payment of $100 for each meeting attended, or $600 per meeting.

The budget as submitted to the Council was recommended for approval.

There was considerable discussion by the Council, following a presentation by Doctor Kief, of the recommendation stated above in reference to PACE.

A motion to restore the appropriation in the same amount as in 1970 lost, and on motion of Doctors Chojnacki–Mauthe, carried, the Council approved the 1971 Operating Budget for the Society general fund as proposed by the Finance Committee, which includes a contribution to PACE for educational purposes of approximately $10,000, or one half the 1970 appropriation.

B. Health Insurance Benefits for Employees and Retirees Age 65 and Over

A staff proposal for retirement health insurance benefits for employees, both those who retire at 65 and those who continue in employment after age 65, was recommended for Council approval. Under the proposal the Society would provide WPS Plus coverage for the employee and for his spouse, with the individuals paying their own Medicare costs.

C. Use of Commercial Paper for Investments

A staff recommendation, with which investment counsel agrees, was to make better use of surplus Society funds by receiving authorization to invest in short-term commercial paper. The Finance Committee recommended that the appropriate officers be authorized to invest surplus funds in Treasury Bills, Treasury Notes, or Commercial Paper, whichever appears best at the time.

On motion of Doctors Egan–Hollenbeck, carried, the Council accepted the Finance Committee recommendations on retirement health insurance benefits and on short-term investments.

10. Physician Assistant Proposal

The Council received a written report of conclusions reached following February and March conferences held at the Society to formulate a legislative approach for recognition of the physician's assistant in Wisconsin.

On motion of Doctors Mauthe–Egan, carried, the Council adopted the statement of purpose and outline for legislation as recommended by the conference participants, which are incorporated for the record:

STATEMENT OF PURPOSE

The following outline for legislation proposes a method to certify or accredit individuals having, by prior experience or by academic training or both, skills, knowledge and ethical background enabling them to be certified as qualified assistants to physicians.

Acting within the powers of an administrative governmental agency, the Medical Examining Board would have the authority to certify such individuals.

Such certification would not eliminate from the area of public service those who are deemed by physicians themselves to possess sufficient qualifications to accept the delegation of responsibility in a particular or broad area.

Persons so certified may claim to be trained assistants to

a physician and surgeon and are entitled to use the designation of physician assistant or the initials "P. A."

They would be employees of licensed physicians but may not be self-employed. The purpose of this provision is to assure the public that the "P.A." shall not practice without the guidance and supervision of a permanently licensed physician.

Because this legislation necessarily anticipates a development but cannot foresee all the resulting problems, it will expire five years after enactment unless renewed by the Legislature, and following interim reports by the Medical Examining Board.

OUTLINE FOR LEGISLATION RELATING TO THE PHYSICIAN'S ASSISTANT

1. No license, certification, or registration shall be required for an individual acting as an assistant to and under the direction and supervision of a permanently licensed physician, but notwithstanding any statutory provision to the contrary, no individual shall hold himself out as a physician's assistant, or use the initials "P.A." unless so certified by the Medical Examining Board. The Board shall consider general education, training and experience in certifying such individual. (If a listing of those who are or are interested in becoming a physician's assistant is to be developed, it should be done under administrative regulation rather than become a part of the initial law.)

2. Such individual may be employed by one or more physicians, but shall not be self-employed.

3. Exemption from the proposed statutes of those already licensed, certified or registered under Wisconsin law, who are allied with the practice of medicine.

COMMENT: Exemptions would include, without being limited to, registered nurses, trained practical nurses, physical therapists, optometrists, and podiatrists when practicing within the areas for which they are licensed, certified or registered.

4. Grant power to the Medical Examining Board to exempt technologists certified or registered by national bodies whose standards have been investigated and approved by the Board.

5. Establish an Advisory Committee or Council under the Medical Examining Board to develop certification standards for recommendation to the Board. In addition, call for a special report by the Medical Examining Board to the Legislature on or before December 31, 1973, as to the Board's experience, together with recommendations if any, for modification of the law, which shall expire five years from the date of enactment, unless renewed by the Legislature.

11. Statement on Prepaid Plans

The Executive Committee reported that this was not yet in form for presentation to the Council and could be anticipated at the May meeting.

12. Commission on Medical Care Plans

Mr. Koenig reported for Doctor Dessloch on highlights of Commission activities and WPS operations which will be elaborated in the annual report to the Council and House of Delegates. Included in his remarks were the subjects of the favorable financial result at the end of 1970; an agreement with Surgical Care over use of the name "Blue Shield" by the two Wisconsin plans, inquiries from county societies and other groups concerning prepaid plans; and activities of the Advisory Committee on Utilization Review.

In response to questions, he also commented on negotiations for the State employees health insurance coverage for the year beginning July 1.

13. Terms of Nonmedical Members of Commission on Medical Care Plans

On motion of Doctors Egan–Mauthe, carried, the Council affirmed that the five nonmedical members of the Commission are to serve three-year terms, as do the physician members, the initial terms to be staggered.

14. Committee on Disaster Medical Care

This committee has not met since 1961 and requested that it be disbanded. Any questions concerning disaster planning at a state level could be handled by the Council or other committees on assignment.

On motion of Doctor Schmidt, seconded and carried, the committee was discharged with thanks for its earlier work.

15. Report of AMA Delegation

Doctor Galasinski reported for the delegation on the volume of business considered at the Boston meeting last December, as well as major subjects of discussion and action. He also asked for the help of councilors and officers in electing L. O. Simenstad, M.D., as Vice President of the AMA.

On motion of Doctors Chojnacki–Ludwig, carried, the report was accepted by the Council.

16. Professional Liability

Mr. Kluwin reported he has received a considerable number of contacts from physicians since announcement to the membership of his assignment to provide consultation and advice on professional liability insurance and related problems. He also discussed a malpractice evaluation panel system instituted in Pennsylvania following an order by its insurance commissioner relative to the cancellation of medical malpractice insurance policies and formation of an ad hoc committee of medical, legal and insurance representatives to work out a solution of the overall problem.

He proposed that the Society approach the Wisconsin Commissioner of Insurance on formation of a similar committee.

The Council encouraged him to proceed with this, and also asked for more information in May on the program Travelers is discussing with several state medical societies.

17. James M. Sullivan, M.D.

On motion of Doctors Foley–Chojnacki, carried, the Council sent its best wishes to Doctor Sullivan, Vice-chairman.

18. Medical Society of Milwaukee County—Constitution and Bylaws

On motion of Doctors Chojnacki–Foley, carried, the Council accepted the report of the Secretary that, with recent amendments as previously recommended by the Council, the Constitution and Bylaws of the Medical Society of Milwaukee County are not in conflict with the Constitution and Bylaws of the State Medical Society as presently adopted.

19. Executive Session on Personnel Matters

An executive session was held prior to recess in which salary increases were approved for Secretary Thayer and Associate Secretary Koenig.

Mr. Thayer reported his plans to redesignate key staff assignments and titles to more adequately reflect the responsibilities of these positions:

Mr. Brower to be director of socio-economic medicine

Mr. Maroney to be director of public affairs and assistant secretary

Mr. Koenig to continue as associate secretary and insurance director

Mr. Reynolds to continue as director of scientific services; Mr. McIntyre as director of government programs and assistant insurance director; and Mr. Lockerbie as sales director

The Council recessed until 10 a.m. Sunday, March 28, when it reconvened following a meeting of the SMS Realty Corporation.

20. Program for Periodic Medical Examinations for Society Employees

On motion of Doctors Nereim–Edwards, carried, the proposal forwarded by the Executive Committee was laid over for further consideration.

21. National Health Insurance Proposals

The Council received a comparative analysis of five major national health insurance proposals, and a policy statement as proposed by the Executive Committee on the financing of personal health services as embodied in these proposals.

On motion of Doctors Egan–Boren, carried, the Council approved publication of the analysis and statement in the next issue of the *Wisconsin Medical Journal.*

22. Commission on Safe Transportation

The Commission recommended that the Council go on record calling for the Society to encourage the appropriate regulatory body within state government to promulgate rules for the safe operation of snowmobiles. It believes that educational programs and safety regulations are needed to help curb the ever-mounting injury rate.

On motion of Doctors Boren–Davenport, carried, the Council encouraged the promulgation of rules for the safe operation of snowmobiles.

23. Guide for School Health Examinations

The Division on School Health recommended that this guide be sent to all physicians in the state, or at least to those in general practice and certain specialties. This would cost from $1700 to $2200 to circulate as a supplement to the *Journal* or by direct mail.

On motion of Doctors Edwards–Manz, carried, the Council concluded that its availabilty for $1 per copy should be publicized in the *Journal.*

24. Foundations for Medical Care; Health Maintenance Organizations; Peer Review

Messrs. Brower and Murphy gave a progress report on staff and consultant studies of this overall subject matter. The Council was advised that more definitive recommendations could be anticipated at the May meeting, contingent to some extent upon the status of federal legislation.

On motion of Doctors Egan–Davenport, carried, the report was received as information.

25. AMA–ERF Chairman for Wisconsin

On motion of Doctors Egan–Schmidt, carried, W. D. James, M.D., was named to this position.

26. Further Report of Executive Committee

A. Appointments to Councils of the Division of Health

On motion of Doctors Edwards–Nereim, carried, the Council approved the Executive Committee's recommendation for reappointment of Doctor Hill of Madison to the Council on Nursing Homes, and Doctor Housner of Richland Center to the Council on Hospital Construction.

B. Special Commendation

On motion of Doctors Edwards–Schmidt, carried, the Council approved the recommendation, as suggested by the Commission on Scientific Medicine, that the Society recognize the cancer control research of Howard Temin, Ph.D., of the University of Wisconsin.

C. CHAPS Study in Wisconsin

The committee reported the nomination of Councilor Edwards to represent the Society on an advisory committee in development of a study project to select an area in Wisconsin for a comprehensive health service plan. This will be conducted under agreement between the State Division of Health and the American Public Health Association represented by the Community Health Action Planning Service (CHAPS).

27. Miscellaneous

The Chairman announced that Doctor Goldstein wished to terminate as Editorial Director of the *Wisconsin Medical Journal,* and asked councilors to be thinking of candidates for the position for election in May.

It was agreed that the summer Council meeting would be held the last weekend in July, whether in Madison or elsewhere to be decided.

Mr. Crownhart asked for the Council's help in promoting membership in Wisconsin Association of Professions, and memorial contributions to the CES Foundation.

Mr. Thayer told of plans for the formal opening of the Museum on May 1 by Governor Lucey. Councilors and officers will be invited to the dinner that evening.

Councilors were asked to submit any additions to the resource list of physicians for nomination by the Society for appointment to state boards, agencies, advisory committees, and voluntary health organizations.

28. Adjournment

The meeting adjourned at 11:20 a.m.

EARL R. THAYER
Secretary

Approved:
E. J. NORDBY, M.D.
Chairman

□

ARE YOU INTERESTED IN MEDICAL HISTORY?

THE ACADEMY OF MEDICAL HISTORY (formerly Section on Medical History) of the State Medical Society of Wisconsin is seeking more members for support of its projects in this interesting and rewarding field. As one of its projects, the Academy publishes a quarterly newsletter that highlights the many contributions of medical memorabilia to the Museum of Medical Progress and the CES Foundation and features on-going activities relating to the collection and preservation of Wisconsin medical history. Although physicians comprise a large percentage of the membership, others too belong, including widows of deceased physicians and persons close to the medical community. The Academy has more than 500 members now, it welcomes many more. The annual dues is only $5.00, payable to the Academy of Medical History, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

SECTION OPHTHALMOLOGY

JULY 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

CHRONIC OPEN-ANGLE GLAUCOMA: A PRACTICAL VIEW

Chronic open-angle glaucoma is a less perplexing disease if the patient receives a methodical, one-stop examination. Although the one-stop examination may seem to be impractical in a private office, if it can be accomplished, it will ultimately save time and avoid the confusion that ultimately results from a piecemeal approach to patient evaluation.

The emphasis on aqueous dynamics during the past two decades has been invaluable in giving us a better understanding of physiologic and pathologic mechanisms and in evaluating populations. It has been of less value than we might have hoped in diagnosing chronic open-angle glaucoma in the individual patient and of minimal value in determining whether therapy is satisfactory. The day of the "magic number" is rapidly passing and with it goes Po/C. Tonography as applied to the individual patient increasingly appears to have a qualitative rather than a quantitative value. It seems possible that its ultimate value will lie more in the area of determination of mechanism than in the diagnosis of disease.

As the glaucoma research pendulum swings from the anterior segment to the posterior segment, the ophthalmologist is obliged to retreat from the "magic numbers" to a position requiring somewhat more judgment and logic. His old friends, the tonometer and ophthalmoscope, stand by him and his manipulation of these once again form the basis of his therapeutic judgment in the glaucomas. Visual fields have an enormous potential in the glaucomas that have yet to be realized in most private offices and many universities. The practitioner must realistically appraise his ability to obtain quantitative, reproducible visual fields. If these can be achieved, or are being achieved with his patients, he is indeed fortunate, and a valuable parameter is available to him and his patients. However, he must be aware that while it is impossible to over-value, quantitative, reproducible visual fields, it is likewise impossible to under-value less than ideal visual fields.

Chronic open-angle glaucoma is a disease in which the eye is unable to maintain homeostasis. Thus it can be moved off course by a variety of endogenous and exogenous influences and provocative tests. These provocative tests, while of academic interest, are of questionable value in practical handling of glaucoma patients. An exception is pilocarpine. Treatment of one eye with pilocarpine in a glaucoma suspect not only demonstrates whether the eye can have its homeostasis significantly disturbed but also it determines whether it can be disturbed in a favorable direction with a safe medication. If intraocular pressure is reduced more than approximately 5 mm/Hg in a glaucoma suspect with pilocarpine, and if the pilocarpine is tolerated satisfactorily by the patient, it is certainly desirable to continue therapy. On the other hand, if pilocarpine either fails to reduce intraocular pressure significantly or the patient finds its side effects intolerable, therapy can be discontinued providing the initial pressure is not greater than 30 and the optic discs are not suspicious. If the optic discs are of concern to the ophthalmologist or visual field change has already occurred, then the ophthalmologist must be prepared to "go for broke" and utilize all medications available to him while encouraging the patient to tolerate side effects in an attempt to reduce pressure to a satisfactory level. If medications are unsuccessful and the ophthalmologist has decided that he and his patient are in the "go for broke" mode, any progression of functional loss requires surgery.—KENNETH T. RICHARDSON, MD

Presented at the Milwaukee Ophthalmological Society Meeting, May 12, 1971, in Milwaukee.

Doctor Richardson is Professor and Chairman, Department of Ophthalmology, University of Pittsburgh School of Medicine and Eye and Ear Hospital.

MARSHFIELD'S EYE BANK

Marshfield's contemplated role in the Wisconsin Lions Eye Bank was outlined before the local Lions Club April 11 by Thomas Stram, MD, Marshfield Clinic ophthalmologist who is cooperating with the Marshfield Lions Club in planning such participation in the Wisconsin Lions Eye Bank.

DATES TO REMEMBER

Sept. 20–24: Annual Meeting, American Academy of Ophthalmology and Otolaryngology, Convention Center, Las Vegas, Nev. Further info: C. M. Kos, MD, Exec. Secy.–Treas., AA00, 15 Second St., S.W., Rochester, Minn. 55901.

Oct. 23: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Lake Delton.

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Two New State Health Planning Bodies Under Way

Pleas for health care reform and medical school funding were aired at the second meeting of the 46-member Health Care Task Force appointed by Governor Lucey. The panel, headed by Madison industrialist David Carley, heard a report by George Handy, MD, State Health Officer, declaring that "social revolution" has created a sophisticated consumer who demands better health service and a reshaping of health care policy.

"The physician's halo is gone," declared Dr. Handy. We can no longer impose our will on the people. Medicine is fast becoming a "public utility."

He said the consumer now has the power and the political force to exert it.

Donald Slichter, retired Milwaukee insurance executive who headed a medical education task force in 1966–67, told the group that funding for both medical schools must be "top priority" in the Legislature. He said a third medical school "doesn't make sense" in light of the state's financial condition and the practical fact that it is easier and faster to improve the existing schools.

The Task Force will next meet on September 13 when it is to discuss a preliminary report to the Governor on its views of the problems Wisconsin faces in the health care field. Meanwhile, the Task Force will hold public hearings at at least five locations in the state to obtain consumer reaction and opinion about health care.

John Hirschboeck, MD, coordinator of the Wisconsin Regional Medical Program, told the Task Force that WRMP has a "new mission" that extends beyond problems of heart, stroke, cancer, and related diseases. The new emphasis is on "implementing delivery of health care" across the board.

At its first meeting June 4, the Task Force attempted to identify health and health service problem areas in Wisconsin.

In small group discussions many of the members pointed out that there is much that is good about what is being done today and upon which to build in the future. But the day's assignment was to list the problems which must be dealt with in creating new state policy.

Members were asked to rank the problems they identified, starting with the most serious. Items topping group lists included high health costs, lack of commitment to the right of good health care for all, lack of planning, distribution of health services based on ability to pay rather than health care needs, and lack of paraprofessionals. Entries ranged from problems due to inadequate public knowledge about health care and diseases to problems in government and attitudes of health professionals.

By the end of the meeting lists of "major barriers" to Wisconsin health care numbered well over 100, with some overlap. Subcommittees are to be formed for detailed study of individual items.

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Amendments to Physician Assistants Bill Threaten Entire Purpose of Program

The State Medical Society's proposal to certify Physician Assistants has the backing of more than 70 Assemblymen and Senators but is faced with a barrage of objectionable amendments which officers of the Society say may threaten the entire purpose of the bill.

Legislation to certify Physician Assistants was originally developed by the Society at the request of the Governor and the Wisconsin Legislative Council through a series of meetings involving 60 or more representatives of the health professions and government. Assembly Bill 707 and Senate Bill 463 embody the principles resulting from these discussions.

Recently, however, amendments have been introduced to permit the employment of Physician Assistants by hospitals, the addition of three hospital administrators to the Wisconsin Medical Examining Board, and a series of "fence me in" amendments from nursing, pharmacy, dentistry, optometry, and the dental hygienists. The latter amendments would, in effect, prohibit a physician from using a Physician Assistant in performing any of the services provided by those licensed or certified in these occupations or professions.

The Society believes the original bill should be passed by the Assembly and Senate without amendment to set up an experimental program. If experience indicates change in the law, it should be made at a later date.

Society Holds First Medical Awards Ceremony

The State Medical Society's first Medical Awards Ceremony was held June 13 preceding the Presidential Reception for the Society's new president, George A. Behnke, MD of Kaukauna.

More than 200 persons attended both functions held at the Society headquarters in Madison.

The following awards were presented:

PRESIDENTIAL CITATION: Roy T. Ragatz, Madison

GUNNAR GUNDERSEN GOLD MEDALLION AWARD: William M. Toyama, MD, Marshfield

INTERSTATE POSTGRADUATE TEACHING AWARD: William W. Engstrom, MD, Milwaukee

AMERICAN MEDICAL ASSOCIATION VOLUNTEER PHYSICIANS FOR VIET NAM AWARD: Bernard B. Rhomberg, MD, Milwaukee

SPECIAL COMMENDATION: Howard M. Temin, PhD, Madison

FIFTY-YEAR CLUB: Harry Beckman, MD, Milwaukee; Arno R. Langjahr, MD, Milwaukee; Wendell A. Killins, MD, Carmel, Calif.; Rose A. Kriz-Hettwer, MD, Milwaukee; Ralph L. Troup, MD, Green Bay; Joseph W. Steckbauer, MD, Manitowoc; Olaf E. Satter, MD, Prairie du Chien; Joseph J. Adamkiewicz, MD, Milwaukee; Roger C. Cantwell, MD, Shawano; George F. Kelly, MD, Berkeley, Calif.; Linwood C. Gardner, MD, Fond du Lac; Edwin F. Schneiders, MD, Madison; Karver L. Puestow, MD, Madison; and Ben Spalding Hill, MD, Kenosha.

The Society's president, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a nonphysician who has made a significant contribution to medicine or public health. Since the establishment of the Citation in 1959, nine persons have been so honored.

Making the presentation to Roy T. Ragatz of Madison was the Society's immediate past president, Jerry W. McRoberts, MD, of Sheboygan.

Mr. Ragatz served the State Medical Society as assistant secretary from 1944 until 1967 when he assumed the position of project director for the Wisconsin Regional Medical Program. He also continues as executive director of Interstate Postgraduate Medical Association whose headquarters are in Madison.

Dr. McRoberts recognized Mr. Ragatz' early association with the Wisconsin Education Association from which he "developed a lifelong respect and admiration for teaching. A respect which has been the basis for his outstanding contribution to medical science and the health of the public."

As an assistant secretary of the State Medical Society, Dr. McRoberts said, "he distinguished himself as a national leader in working with the medical profession in planning and implementing postgraduate scientific programs."

"Mr. Ragatz was honored in 1966 by a large group of physicians for his many years of work with the Maternal Mortality Study Committee of the Society, a work he approached with the vigor, dedication and true feeling for humanity which has become a trademark of his character," Dr. McRoberts continued. And quoting from the official publication of the Professional Convention Management Association, Dr. McRoberts remarked: "Roy T. Ragatz . . . gets the show on the road with his serious comments, sparked with a humorous touch. An authority in the convention field, as well as an outstanding and entertaining speaker, Roy rates at the top of the list when program chairmen are issuing invitations."

The Gunnar Gundersen Gold Medallion Award was established in 1966 to honor one of Wisconsin's most distinguished physicians and citizens, Gunnar Gundersen, MD of La Crosse, who is a former president of both the American Medical Association and the State Medical Society of Wisconsin.

Presenting the award to William M. Toyama, MD of Marshfield was Society president, George A. Behnke, MD of Kaukauna. The award was granted Dr. Toyama for his exhibit entitled "Open Pulmonary Biopsy in Children," which he originated and produced for the 1970 Annual Meeting of the Society in cooperation with the Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education.

PRESIDENTIAL CITATION awarded to Mr. Ray T. Ragotz, Madisan (r), executive director af Interstate Pastgroduote Medicol Associatian, by Jerry W. McRaberts, MD, Shebaygon, immediote post president af the State Medical Saciety.

THE ERWIN R. SCHMIDT INTERSTATE TEACHING AWARD was presented by Nels A. Hill, MD, Madison (l), to Williom W. Engstram, MD, Milwaukee.

Dr. Toyama has been associated with the Marshfield Clinic in the Department of Radiology and Pathology since August 1967 with the full-time specialty of general surgery, and a special interest in pediatric surgery.

The Interstate Postgraduate Teaching Award was presented to William W. Engstrom, MD of Milwaukee by Nels A. Hill, MD of Madison, a member of the Interstate Board of Trustees.

The award is given annually to a Wisconsin physician who has distinguished himself in the area of teaching of medical students and physicians in practice. The award includes a $500 cash grant and a plaque.

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MEDICAL GREEN SHEET is published monthly os a special feoture in the *Wisconsin Medical Jaurnal*, officiol publicotion of the Stote Medicol Society of Wisconsin, to provide current news of socio–economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medicol Society of Wisconsin, Box 1109, Modison, Wis. 53701.

MANAGING EDITOR: Eorl R. Thoyer, Secretory, Stote Medicol Society of Wisconsin.

FIFTY-YEAR CLUB: (l-r) Roger C. Cantwell, MD, Shawano; Ralph L. Troup, MD, Green Bay; Rose A. Kriz-Hettwer, MD, Milwaukee; Edwin F. Schneiders, MD, Madison; and Karver L. Puestow, MD, Madison.

MEDICAL AWARDS

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Dr. Engstrom is professor and chairman of the Department of Medicine, Medical College of Wisconsin, Milwaukee. He specializes in internal medicine and endocrinology. Dr. Engstrom is the first professor to hold the Francis D. Murphy chair at the medical college. Dr. Engstrom succeeded Dr. Murphy as chairman of the Department of Medicine.

The AMA's Volunteer Physicians for Viet Nam Citation was presented to Bernard B. Rhomberg, MD of Milwaukee by L. O. Simenstad, MD of Osceola, in recognition of his volunteer service in Viet Nam from July to September 1970. Dr. Rhomberg is a resident in anesthesiology at the Medical College of Wisconsin.

A Special Commendation was issued to Howard M. Temin, PhD of Madison by President Behnke who noted Prof. Temin's contribution to medical science and specifically to genetic knowledge as reported in "Newsweek" magazine in an article entitled, "The War on Cancer: Progress Report."

Five of the 14 physicians who became members of the Society's Fifty-Year Club were present to accept the special honor of entering the club. They are pictured elsewhere on this page.

The Society annually pays its respect to members who have served their profession and patients for 50 years. It is an honor which is expressed by fellow practitioners on behalf of the communities and patients who have been served by physicians of experience and integrity.

Auxiliary Establishes Crownhart Loan Fund

The Woman's Auxiliary to the State Medical Society has established a Charles H. Crownhart State Student Loan Fund with a $300 contribution to the Society's Charitable, Educational and Scientific Foundation.

The Auxiliary's action was taken at the May Annual Convention in Milwaukee.

In making the announcement, Mrs. Dale Moen of Shell Lake, immediate past president of the Auxiliary, said, "We shall encourage the growth of this fund in the future hoping it will continue to be a tribute to your (Charles H. Crownhart) sincere efforts in behalf of the medical profession."

Mr. Crownhart, who retired as secretary of the State Medical Society at the end of 1970, was a guiding force in the development of the Woman's Auxiliary during his 29 years as secretary.

MD Dial Access Service on Subscription Basis

The Wisconsin MD Dial Access Library service, provided without cost since 1968 through funding of the Wisconsin Regional Medical Program (WRMP), will be placed on a subscription basis starting Sept. 1, according to Thomas C. Meyer, MD, Associate Dean of the University of Wisconsin Medical School, and Director of the Dial Access Library.

"We have been most encouraged by the many Wisconsin physicians who have indicated interest in continuation of the program," said Dr. Meyer when asked about the future of Dial Access, "and with all who have used the system supporting it to the extent of $25 per year, we can expand the Library and make it an effective teaching resource in the state."

Any subscriber will receive a new brochure listing all the 500 tapes in the Library, and will be issued a new number to call for the service. Also, each subscriber will receive periodic notices as new tapes are added to the Library.

At present Minnesota, North Dakota, and all VA hospitals served by the Federal Telephone System are directly connected with the Library which is maintained at the Madison campus of the University of Wisconsin.

All Wisconsin physicians interested in subscribing to this service are requested to send a check of $25 (payable to the University of Wisconsin) to: Thomas C. Meyer, MD, 610 N. Walnut St. (Room 575), Madison, Wis. 53706.

47 Externs in Summer Program

This summer 47 first year medical students are learning what family practice is all about by living and working with general practitioners in Wisconsin.

The second summer externship administered by the Society's CES Foundation is under way with 50% more participants than last summer.

The 10 week "live in" experience involves 36 University of Wisconsin medical students mostly assigned to small towns and 11 students from the Medical College of Wisconsin in Milwaukee, who are assigned to Milwaukee area hospitals. Each student receives a $750 fellowship.

Financial support for the program comes from WPS–Blue Shield, Surgical Care–Blue Shield, the Wisconsin Rural Rehabilitation Corporation and the Indianhead Chapter of the Wisconsin Academy of General Practice. Physicians and hospitals hosting participating students also provide funding in addition to providing students' room and board.

The program was initiated by the Wisconsin Academy of General Practice, an organization of 850 family doctors in the state.

State Health Planning Bodies

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During the 18 months of its existence, the Task Force must draw up proposals for state health planning, policy, and legislation. A preliminary report to the Governor is due next October with final recommendations to be made by October 1972.

The first meeting is scheduled for this month of the other new health planning body created by the Governor this spring, the Health Policy and Program Council. Ben R. Lawton, MD, of Marshfield is chairman of the Council, which is to be a more permanent body, combining five existing councils charged with administering federally funded programs. Those are comprehensive health planning, developmental disabilities, hospital construction, mental health centers construction, and facilities for the mentally retarded.

The Council's 37 members include 17 health providers—five MDs, three hospital and clinic administrators, two nurses, three government officials, and four representatives of private associations—and 20 health consumers drawn from business, labor, health associations, and minority groups.

The Task Force members include 10 MDs and others in such health related fields as hospitals, health insurance, and social work.

There is some overlap of members between the Task Force and Council, since ongoing programs will be a consideration of Task Force planners. Those appointed to both bodies are:

Council Chairman Ben R. Lawton, MD, Task Force Chairman David Carley, State Medical Society Secretary Earl Thayer, medical school deans P. L. Eichman, MD and G. A. Kerrigan, MD, State Dental Society representative L. J. English, DDS, WRMP Coordinator John S. Hirschboeck, MD, Wisconsin Hospital Association Executive Director Warren Von Ehren, and Mount Sinai Hospital (Milwaukee) Administrator Ray Alexander.

Members of the Health Planning and Policy Task Force are:

David Carley, Madison, Chairman; Ben R. Lawton, MD, Marshfield, Vice-Chairman; Ray Alexander, Milwaukee; James Anderson, La Crosse; William Blockstein, Madison; Barbara Brown, Milwaukee; Robert D. Coye, MD, Madison; Ralph Daum, Kenosha; Robert Durkin, Milwaukee;

Peter L. Eichman, MD, Madison; David B. Elesh, Madison; L. J. English, DDS, Arcadia; Marshall Erdman, Madison; Walter Gleason, Elkhorn; Paul R. Glunz, MD, Beaver Dam; Stanley N. Graven, MD, Madison; George Handy, MD, Madison; Rick F. Heber, Madison;

Jean M. Helliesen, La Crosse; Leonard W. Hickey, Columbus; Inez Hinsvark, Milwaukee; John Hirschboeck, MD, Milwaukee; Wendell Hunt, Milwaukee; Mrs. Winona G. Jackson, Milwaukee; D. C. Jacobus, Milwaukee; Kenneth Jamron, Milwaukee; Laflin C. Jones, Milwaukee;

John Kelly, Milwaukee; Gerald A. Kerrigan, MD, Milwaukee; John Martin, Madison; Stanley Matek, Milwaukee; Robert E. McMahon, MD, La Crosse; Norman Mitby, Madison; Raymond C. Munts, Madison; John Peterson, MD, Milwaukee; Susan K. Phillips, Madison; Dennis J. Purtell, Milwaukee; Barbara Shade, Madison; Gilda B. Shellow, Milwaukee; Leo Suycott, Milwaukee; Earl Thayer, Madison; Warren Von Ehren, Madison; and Peter Weiss, Madison.

Recently appointed as working staff members of the Task Force are Coordinator John Gregrich, formerly assigned to health matters in the state Department of Administration; Staff Coordinator Miss Sarah Dean, New York City; and Policy Planning Advisor Marc Hansen, MD, Assistant Dean of the University of Wisconsin Medical School.

Six legislative advisors have also been appointed to the Task Force: Senators James C. Devitt, Raymond F. Heinzen, and Carl Thompson; and Representatives Dennis Conta, Joseph C. Czerwinski, and William G. LaFave.

Health Policy and Program Council members include representatives of two groups:

Providers—Ben R. Lawton, MD, Marshfield, Chairman; Ray Alexander, Milwaukee; Don J. Eibe, Baldwin; Peter L. Eichman, MD, Madison; L. J. English, DDS, Arcadia; Tom Frangos, Madison; John Hirschboeck, MD, Milwaukee; Gerald A. Kerrigan, MD, Milwaukee; Gerald A. Larson, Milwaukee; John W. Maxwell, Jr., MD, Milwaukee; John Melcher, Madison; William R. Merchant, Madison; Valencia Prock, RN, Madison; Jean Ripp, RN, Monroe; Wilbur J. Schmidt, Madison; Earl Thayer, Madison; Warren Von Ehren, Madison;

Consumers—Mrs. Duane (Alita) Barmore, Madison; Charles Bergstrom, Superior; David Carley, Madison; Ken Clark, Milwaukee; Mrs. Robert Dineen, Milwaukee; T. A. Duckworth, Wausau; James F. Egan, Mequon; Robert Friebert, Milwaukee; James Gebhard, Stevens Point; John Gesicki, Edgar; Mrs. Gunnar (Betty) Gundersen, La Crosse; Mrs. David (Eara) Hollins, Milwaukee; Harris Mahan, Superior; Mrs. Louise Mueller, Germantown; George O'Donnell, Milwaukee; Juanita Renteria, Milwaukee; Harold Ristow, La Crosse; Arthur Salzstein, Milwaukee; Sandra Waubanascum, Madison; Mrs. Crawford (Rebecca) Young, Madison.

G. J. Derus, MD

B. R. Lawton, MD

Dr. G. J. Derus Heads Scientific Medicine

Gerald J. Derus, MD of Madison was named chairman of the Commission on Scientific Medicine when it met in June to begin planning the 1972 Annual Meeting Program and other scientific matters.

Named general program chairman for the 1972 meeting was Einar R. Daniels, MD of Wauwatosa.

Other appointments for the 1972 Annual Meeting include: S. E. Sivertson, MD, Madison, chairman of special teaching programs; Robert G. Wochos, MD, Green Bay, chairman of scientific exhibits; and Edwin C. Albright, MD, Madison, chairman of the resident–intern papers program.

Narcotics Registration Deadline: July 29

The deadline for use of physician registration numbers under the Controlled Substances Act has been extended to July 29.

Physicians who have not yet received the new number should immediately contact their nearest BNDD Regional Office: Bureau of Narcotics and Dangerous Drugs, Engineering Building, Suite 1700, 205 West Wacker Drive, Chicago, Ill. 60606; or the Registration Section at P.O. Box 28083, Central Station, Washington, D. C. 20005.

Governor Commends UAW Support of Kennedy Bill

Governor Patrick J. Lucey, speaking at the recent dedication of a UAW building in Janesville, commended the UAW for actively working toward the enactment of the Kennedy National Health Insurance bill. He said, "I think this is a vital and important public service, and I hope that your union and your allies are successful in this effort."

trends

The Wisconsin Regional Medical Program, Inc.

JULY, 1971

WRMP Could Play Major Role In Future Development of New Health Care Delivery System

RMP's Have Organization and Know-How To Carry Out Objectives of President

Regional Medical Programs appear to be making headway in playing a major role in the development of health programs as outlined in President Nixon's health message.

Several sources have indicated that RMP's are the best equipped to handle the suggested changes to be made in the health care delivery system.

In an article recently written by Dr. Harry B. Weinberg, coordinator, Iowa Regional Medical Program, reference was made to HEW Secretary Elliot Richardson saying that "a rational system of health services can derive only from regionalization of those services. On that premise, he sees reason to believe that a constructive role should lie ahead for RMP's in furthering the programs proposed in the President's health message."

In his health message, the President pointed to several major programs in which RMP's could play a major role: The establishment of Health Maintenance Organizations (HMO's) — some RMP's have already established a working relationship with physicians, hospitals and other personnel to help establish these organizations; implementation of the most efficient use of all phases of health technology — RMP's already have established programs and projects which are expanding the effectiveness of the practicing professional and the community hospital; establishment of new Area Health Education Centers as recommended in the Carnegie Commission Report On Higher Education and the Nation's Health — some RMP's through their basic working relationship between the medical schools and the community hospitals are exploring their development; the Emergency Health Personnel Act — many RMP's have had great involvement in establishing new health programs in the rural and highly populated urban areas of our regions; meeting the health manpower shortage — RMP's have been greatly involved in continuing education and in improving the numbers and efficiency of health care personnel.

At a recent meeting in New

(Continued on Page 3)

Health Maintenance Organizations — What Are They All About?

A new set of letters is making its way into the vocabulary of those involved in health care. The new letters are HMO — Health Maintenance Organizations.

A Health Maintenance Organization is an organized system of health care capable of bringing together directly, or arranging for, the services of physicians and other health professionals with the services of inpatient and outpatient facilities for preventive, acute and other care reasonably required by a target population. The system is organized in such a way as to assure for the enrollee the most efficient and effective entry into the health care system. It also promises continuity of care for the enrolled population through linkages between the components of the system.

Primary care, one of the main ingredients of an HMO, emphasizes those services aimed at preventing the onset of illness or disability, at the maintenance of good health, and at the "continuing evaluation and management of early complaints, symptoms, problems and the chronic intractable aspects of disease." It might be more graphically described as "personal physician care."

Anyone is eligible to purchase the services from the HMO through a prepayment plan under which the enrollee (or head of household) agrees to pay the fixed monthly or other periodic payment to the HMO. In this way, the enrollee agrees to use the HMO as his principal source of health care if he becomes ill or needs care.

Health Maintenance Organizations will more than likely play a very important role in the health care delivery system in the very near future. The Wisconsin Regional Medical Program is already preparing itself to cooperate in every way possible with those who wish to establish HMO's in Wisconsin.

Project To Improve Patient Care In Regio Ready To Meet Test In "Real World'

The third and final phase of the Nurse Utilization — A Patient Care Project, is about to begin making available to all hospitals in the Wisconsin Region a new system of health care delivery. The announcement was made by Mrs. Janet M. Kraegel, project director.

The project, funded and administered by WRMP, has been developed with the cooperation of St. Mary's Hospital, Milwaukee, and the University of Wisconsin-Milwaukee School of Nursing. It has successfully developed a system for the more efficient use of hospital staff for the more effective care of the patient.

"Although there are some bugs to eliminate before the system is fully developed, we are at a point, I think, where we can provide enough basic information to help others consider the establishment of the system in their own facility," Mrs. Kraegel said. "We have realigned the work activity of the hospital staff, utilized more efficiently old routine pieces of equipment and have put into operation new equipment for a more efficient operation.

"Our main objective in making the changes in developing this system is to meet the needs of the patient," she continued. "The patient is the target. Actually, you might say we worked backwards. Rather than developing more efficient means of providing the patient with better care, we took the patient, asked what his needs were and worked backwards by developing the means necessary to provide these needs."

The greatest problem the project has faced is that of tradition.

"Because of the changes made in the routine activity of the hospital staff we have been faced with many problems, most of them psychological," she continued. "Tradition is most difficult to break away from. However, after people found how much more efficient the operation became they did more than their share in meeting specific objectives more quickly than anticipated."

One of the major changes in the project is the elimination of the nurse station.

"This was one of our toughest jobs," Mrs. Kraegel added. "The nurse station traditionally has been the focal point of all activity. We found, however, that a great amount of the activity here is paperwork which can be done by a non-health oriented person. By replacing the nurse with this kind of person the nurse is free to do what she was trained to do in providing and planning for the immediate and future needs of the patient on an individual basis.

"We feel we have found a means of providing more clinical competence at the bedside of the patient during his entire hospital stay," she continued. "This means much more than providing the medication when the chart says so. It requires team planning for individual needs. An ambulatory patient has different needs than does a geriatric patient, the needs of a post operative patient are different from those o heart patient. Through care planning of all aspects in the c of the patient, these individ needs can be met successfully sulting in a shorter hospital st and a better patient experie upon his dismissal."

The project required a compl remodeling of a 39 bed medi care unit at St. Mary's Hospit Milwaukee, to work out operati and utilization changes.

Mrs. Kraegel and Miss Virgi M. Schmidt, Associate Director the project, have already given p grams to interested health and h pital personnel in Milwaukee, E Claire, Green Bay, Madison a Wausau. Additional programs w be set up during the next seve months. For additional informati write: Mrs. Janet M. Kraegel, W consin Regional Medical Progra c/o St. Mary's Hospital, 2388 Lake Dr., Milwaukee 53211.

Governor Patrick J. Lucey *(right) questioned Dr. John S. Hirschboeck, WRMP Coordinator, about the health care delivery system in Wisconsin. The discussion took place in front of the WRMP exhibit which will be located in the State Capitol through July.*

'overnor Lucey 'ames 43 To 'ealth Task Force

Nine members of a 43 member ealth Planning and Policy Task rce appointed by Governor Patrick Lucey, are associated with the Wisnsin Regional Medical Program.

The task force was announced last onth by the Governor to study the ate's health needs and report its idings to him in 18 months.

Named were: Dr. John S. Hirschck, Coordinator, WRMP; Dr. Peter Eichman, Dean, University of Wisnsin Medical School, WRMP Board Directors; Dr. Gerald A. Kerrigan, an, Medical College of Wisconsin, RMP Board of Directors; Dr. orge Handy, Director, Division of alth, State of Wisconsin; Dr. John Petersen, Director of Medical Servs, Milwaukee County Hospital, and arren Von Ehren, Executive Dictor, Wisconsin Hospital Associaon, members of the WRMP Regional dvisory Group; William Blockstein, ofessor, University of Wisconsin xtension, WRMP Review and Evalations Committee; Miss Inez Hinsrk, Dean, University of Wisconsinilwaukee School of Nursing, WRMP ursing Committee; Dr. Ben R. Lawn, Marshfield Clinic, WRMP Heart udy Group. Dr. Lawton was also med vice chairman of the task force.

Also named were: David Carley, Ind Steel Development Corp., Madison, airman; Ray Alexander, Administrator, t. Sinai Hospital, Milwaukee; James nderson, Associate Professor-Sociology, isconsin State University, LaCrosse; rs. Barbara Brown, Dept. of Nursing, lverno College, Milwaukee; Robert D. oye, M.D., Professor and Associate ean, University of Wisconsin, Madison; alph Daum, President, UAW Local 72, enosha; Robert Durkin, Vice President, ilwaukee County Labor Council, Milaukee; David B. Elesh, Assistant Prossor-Sociology, University of Wisconsin, adison; L. J. English, D.D.S., Wisconsin ate Dental Society, Arcadia; Marshall rdman, Marshall Erdman & Associates, adison; Walter Gleason, Executive Dictor, Walworth County Hospital, Elk orn; Paul R. Glunz, M.D., Beaver Dam; anley N. Graven, M.D., St. Mary's ospital, Madison; Rick F. Heber, Dictor, Retardation Center-University of isconsin, Madison; Jean M. Helliesen, ssociate Professor-History, Wisconsin ate University, LaCrosse; Leonard W. ickey, Columbus; Wendell Hunt, Asciate Professor, University of Wisconsinilwaukee, Milwaukee; Mrs. Winona G. ckson, Assistant Health Coordinator, ay Care Services for Children, Inc., Milaukee; D. C. Jacobus, Medical Center for outheastern Wisconsin, Milwaukee; Kneth Jamron, Administrator-Deaconess ospital, Milwaukee; Laflin C. Jones, enior Vice President, Northwestern utual Life Ins. Co., Milwaukee; John elly, President, Midland National Bank, Milwaukee; John Martin, Wisconsin Association for Retarded Children, Inc., Madison; Stanley Matek, Executive Director-Mental Health Planning Committee, Milwaukee; Robert E. McMahon, M.D., Gundersen Clinic, LaCrosse; Norman Mitby, Director-Madison Area Technical College, Madison; Raymond C. Munts, Professor-Social Work, University of Wisconsin, Madison; Susan K. Phillips, Alderman-Madison City Council, Madison; Dennis J. Purtell, Milwaukee; Barbara Shade, Madison; Gilda B. Shellow, Milwaukee; Leo Suycott, President, Blue Cross, Milwaukee; Earl Thayer, Secretary, State Medical Society of Wisconsin, Madison; and Peter Weiss, Psychologist, Madison.

Continued from Page 1

WRMP Eyes Possible New Role In Region

Mexico, Dr. Vernon E. Wilson, Administrator, Health Services and Mental Health Administration, noted that the President's health message was very clear.

"It stresses the need for equity to access to the health care system; it advocates building on the present system — not replacing it, but adding complementary programs; and it addresses itself to the prevention of disease and the maintenance of health."

Dr. Harold Margulies, Director, Regional Medical Programs Service, HEW, added to Dr. Wilson's comments at an RMP meeting in Denver.

"Mr. Nixon talked about accessibility, productivity, efficiency and cost and he proposed solutions such as health maintenance organizations (HMO), national health insurance and a closer relationship between academic medicine and health care delivery," Dr. Margulies said.

"RMP must assist in moves to provide greater access of health care, better distribution and utility of manpower and greater effectiveness in the use of resources," he continued.

He further pointed out that the time for categorical approaches toward disease has already passed, indicating that RMP will in the future be taking a much more comprehensive approach to health care.

At the annual meeting of the Comprehensive Health Planning Agency for Southeastern Wisconsin, Dr. Wilson, the guest speaker, also discussed the HMO idea and the Administration's stand on the program.

"Of special interest to us in HSMHA and to you in southeastern Wisconsin are some of the implications of the HMO concept in relation to planning," he said. "I think it can be said that in many communities HMO's will mark a turning point in planning for the full use of community resources to provide a full range of services. On their own initiative, state and local health agencies and planning bodies, as well as medical societies and other health organizations, should think very seriously about how to participate actively in the conceptual developmental and operating phases of HMO's and other community health delivery systems."

To help get HMO's started, the Administration is asking for a new $23 million program of planning grants to aid potential sponsors, in both the private and public sectors.

There has been some discussion to the effect that Regional Medical Programs would be the best equipped to assist in the development of HMO's on a regional basis as well as develop Area Health Education Centers (AHEC's) as outlined in the recently published report of the Carnegie Commission.

Because of the cooperation and coordination needed at both the private and public levels to implement this type of program, Regional Medical Programs could be called upon to serve as the linking agent in the system.

"The news coming out of Washington recently is certainly welcome after the recent cutbacks in funding," said Dr. John S. Hirschboeck, WRMP Coordinator. "It appears that Regional Medical Programs are beginning to receive the recognition long overdue. In Wisconsin, as in many regions, we are and have been doing much of what is now being discussed. I believe our foresight at the local level demonstrates how an RMP can quickly respond to national trends. We have the organization and working affiliations to move quickly in the direction outlined by the President. All that is necessary is access to the funds already appropriated by the Congress to do the job."

The President's Health Maintenance Organizations

By John S. Hirschboeck, M.D.
Coordinator, Wisconsin Regional Medical Program

President Nixon is promoting the establishment of Health Maintenance Organizations. What are they? Will the Wisconsin Regional Medical Program have a role in their implementation?

It seems to me that too much attention is being focused on the insurance and financial aspects of the HMO's without probing into their real purpose which is to create a system emphasizing the maintenance of health. Today, most physicians and health professionals are principally concerned with the diagnosis and treatment of specific diseases. Health maintenance is apt to be a secondary concern frequently overlooked in a crowded medical practice. Physicians who feel committed to practice health maintenance are discouraged because the financial reward for the effort is so much less than what can be earned in treating illness. President Nixon in his recent health message referred to the old Chinese custom of paying a physician to keep one healthy and well. Introducing the concept of managing wellness in order to forestall illness will require a change of emphasis in health profession education and in the operation of the health care system.

WRMP has the capacity to mobilize talent and resources to provide consultation and assistance to those who are developing Health Maintenance Organizations and to assure them that the health maintenance approach is adequately taken care of. WRMP could assist a hospital or a group of physicians to organize the professional components for their Health Maintenance Organization. WRMP, through its association with the universities, medical schools, professional societies, and hospitals, is uniquely capable of undertaking this responsibility. If the Health Maintenance Organization concept is adopted as national policy, the Regional Medical Programs may well be the instruments for introducing the change needed to reorientate the health care system to function toward the goal of health maintenance.

Trends is published quarterly The Wisconsin Regional Medi Program, Inc., 110 E. Wiscon Ave., Milwaukee, Wis. 53202. A cles for publication can be sent the above address in care of Dir tor, Public Information.

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Dr. Merlin K. DuVal has bee named Assistant Secretary of HEV for Health and Scientific Affairs.

He succeeds Dr. Roger O. Ege berg who has been named a specia advisor to the President.

Dr. DuVal was Director of th University of Arizona Medica Center and Dean of the College o Medicine.

NEWS HIGHLIGHTS

Dr. Alfred Kritter Heads Waukesha Medical Society

New officers were elected at the June 9 meeting of the Waukesha County Medical Society as follows: president—Alfred Kritter, MD* of Waukesha; president-elect—Albert Motzel, Jr., MD*, Waukesha; treasurer—W. J. K. Clothier, Jr., MD*, Waukesha; and secretary—Kenneth Dempsey, MD*, Menomonee Falls.

Three more "SOS" scholarships, funded by the Waukesha County Medical Society, have been awarded to medical and paramedical students in Waukesha County. They raise to 11 the number of scholarships awarded since the fund was established in 1964 with money raised from the Sabin Oral Polio Sunday drive.

Dr. Overholt, La Crosse, Given Outstanding Teacher Award

Edwin L. Overholt, MD,* director of Medical Education and Research at the Gundersen Clinic–Lutheran Hospital, recently was selected by the interns and residents who had completed a year on the house staff, as the recipient of the first annual Gundersen Clinic–Lutheran Hospital Outstanding Teacher Award.

The award, which will be presented annually, was given by MDs Thomas P. Lathrop and Richard W. Claussen. Doctor Overholt has been associated with the Clinic since 1968 when he retired from 23 years of military service.

Two of the 10 interns who have completed their year on the Clinic's house staff will remain at the Clinic in surgical residency. On July 1, twenty-two physicians began a new year of internship and residency at the Clinic–Hospital.

Dr. David Hilton, Menomonie, Addresses Medical Assistants

"Rainbow of Gems," the Sixteenth Annual Meeting of the Wisconsin State Medical Assistants Society was held May 21–23 at the Holiday Inn in Eau Claire.

Contrasting our modern medical facilities and advances was David Hilton, MD,* currently associated with the Red Cedar Clinic in Menomonie. He spent ten years with the United Methodist Mission Hospital in Bambur, Nigeria, and showed slides with his presentation on "Gems in Another Culture."

Dr. Bernhardt Visiting Professor

The eighth annual Visiting Professor Day was held at the Edgerton Memorial Community Hospital on June 2. Louis Bernhardt, MD,* Department of Surgery and Assistant Dean of the University of Wisconsin Medical School, Madison, was the visiting professor. His topic of discussion was "Treatment in the Emergency Room."

PHYSICIAN BRIEFS

Raymond L. Hansen, MD*

. . . Marshfield Clinic allergist, and R. C. Roberts, PhD, research biochemist at the Marshfield Clinic Foundation for Medical Research and Education, are the co-authors of the article, "The Clinical Value of Immunoglobulin Assays—Part One," which was featured in the May issue of Group Practice magazine.

C. A. Klasinski, MD*

. . . Stevens Point, recently qualified for the American Medical Association's Physician Recognition Award for 1970.

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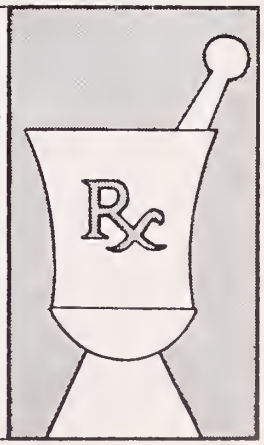

Wisconsin Rated High on Internship Selection

On June 14, one hundred senior medical students from the University of Wisconsin Medical School, Madison, received their doctor of medicine degree. Thirty-two of the graduates will be taking their internships in Wisconsin and California (16 in each state), and the rest in Colorado, Texas, Minnesota, Pennsylvania, New York, Louisiana, Utah, Iowa, Massachusetts, Arizona, Indiana, Ohio, and Illinois.

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Medical College of Wisconsin Receives Institutional Award

The Medical College of Wisconsin has been awarded a $400,000 Special Project Grant by the U. S. Department of Health Education and Welfare's Division of Physician and Health Professions Education. The one-year grant will start July 1, 1971.

Special Project Grants are awarded to eligible health education schools for a number of purposes. These include helping to increase the supply of health personnel, assisting with serious financial problems, improving curriculums, establishing new programs, and otherwise strengthening health training programs.

New Officers, Urological Soc.

At the 1971 annual meeting of the Wisconsin Urological Society recently held in Milwaukee, the following physicians were named to office: MDs T. H. McDonell,* Waukesha, president; Richard H. Troup,* Green Bay, president-elect; and John D. Silbar,* Milwaukee, was reelected secretary-treasurer.

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MEDICAL MEETINGS
POSTGRADUATE COURSES

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1971 WISCONSIN

Sept. 10–11: Annual scientific assembly, Wisconsin Academy of General Practice, Pfister Hotel and Tower, Milwaukee.

Sept. 17–18: Fall Meeting, Wisconsin Society of Internal Medicine, Green Bay. Program Chairman: John M. Irvin, MD, Monroe. On Sept. 17, Dr. Paul Lacy—Mallinckrodt Professor of Pathology at Washington University, St. Louis, Mo.—will speak on Beta Cell Secretion.

Sept. 17–19: Annual Fall Meeting, Wisconsin Surgical Society, The Abbey, Fontana (Lake Geneva).

Sept. 17–19: Annual Meeting, Wisconsin Radiological Society, Kahler's Inn Towne Motel, Wisconsin Dells.

Sept. 18–19: Annual Fall Meeting, Wisconsin Society of Anesthesiologists, Pioneer Inn, Oshkosh.

Sept. 22: Sixth annual Adolf Gundersen Symposium for Physicians—"Understanding Arrhythmias." Co-sponsored by the Wisconsin Heart Association and the Adolf Gundersen Foundation. Valhalla Hall, Wisconsin State University, La Crosse.

Sept. 24–25: Annual Meeting, Wisconsin Academy of Pediatrics, University of Wisconsin Center, Madison.

Sept. 30–Oct. 2: District VI Meeting of American College of Obstetricians and Gynecologists and Nurses Conferences, Loraine Hotel & Park Motor Inn, Madison.

Oct. 15–16: Annual Fall Meeting, Wisconsin Society of Obstetrics and Gynecology, The Abbey, Fontana (Lake Geneva).

Oct. 16: Seventeenth Annual Fall Cancer Conference (scrimmage), Division of Clinical Oncology, University of Wisconsin Medical Center, Madison and Wis. Division of American Cancer Society. Info: Robert J. Samp, MD, University Hospitals, Madison, Wis. 53706.

Oct. 17–23: Wisconsin Work Week of Health.

Oct. 23: Fall Meeting, Wisconsin Society of Pathologists, VA Hospital, Madison. Key speaker at seminar on Pulmonary Pathology: John P. Wyatt, MD, University of Manitoba, Canada.

Oct. 30: Wisconsin Dermatological Society, Wood Veterans Administration Hospital, Milwaukee.

Nov. 20: Annual Meeting, Wisconsin Chapter, American College of Surgeons, St. Joseph's Hospital, Milwaukee.

1971 NEIGHBORING STATES

Sept. 10–11: Conference on Urology, The University of Iowa Health Center, Iowa City, Iowa. Info: Director of Medical Education, Office of the Dean, The University of Iowa, Iowa City 52240.

Sept. 13.–15: *Clinical Electroencephalography.* American Electroencelphalographic Society, in Minneapolis, Minn. Info: Donald W. Klass, MD, EEG Course Dir., Mayo Clinic, Rochester, Minn. 55901.

Sept. 13–18: American Electroencephalographic Society and the American Society of EEG Technologist (ASET) Annual Meetings, Hotel Radisson South, Bloomington, Minn. Info: Mrs. Margaret H. Henry, Exec. Secy., The American EEG Society, 36391 Maple Grove Rd., Willoughby Hills, Ohio 44094.

Sept. 18: 13th Annual Fall Symposium, sponsored by Methodist Hospital, St. Louis Park, Minn., "Problems in Primary Practice," Hopkins House Motel, 1501 Highway 7, Hopkins, Minn. 55343. Info: Harley J. Racer, MD, Methodist Hospital, 6500 Excelsior Blvd., St. Louis Park, Minn. 55426.

Sept. 22–23: Conference on Pediatrics, The University of Iowa Health Center, Iowa City, Iowa. Info: Director of Medical Education, Office of the Dean. The University of Iowa, Iowa City 52240.

Sept. 23–24: First "Comprehensive Conference on Stroke" meeting of American Heart Association's North Central Region, Cobo Hall, Detroit, Mich. Info. Harold Arnow, North Central Regional Office, 799 Roosevelt Rd., Bldg. #4, Rm. 311, Glen Ellyn, Ill. 60137.

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Oct. 8: Annual Meeting of Association of American Physicians and Surgeons, Colony Motor Hotel, Clayton, Mo. Info: AAPS, 230 N. Michigan, Chicago, Ill. 60601.

Oct. 4–9: Postgraduate course in Laryngology and Broncho esophagology, Department of Otolaryngology of the University of Illinois at the Medical Center, University of Illinois Eye and Ear Infirmary, Chicago, Ill.

Oct. 10: Joint scientific meeting, American College of Pre ventive Medicine and Association of Teachers of Preventive Medicine, Hotel Leamington, Minneapolis, Minn.

Oct. 10–15: 14th Annual Meeting, American Society of Clinical Hypnosis, Pick Congress Hotel, Chicago, Ill. Info: F. D. Nowlin, Exec. Secy., 800 Washington Ave., Southeast, Minneapolis, Minn. 55414.

Oct. 16–21: American Academy of Pediatrics 40th Annual Meeting, Palmer House Hotel, Chicago, Ill. Info: Department of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

Oct. 23–29: Annual Otolaryngologic Assembly of 1971, University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill.

Oct. 28–30: *Antibiotics and Infection Course,* University of Iowa, Iowa City.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

Dec. 4–9: Annual Meeting, American Academy of Dermatology, Palmer House, Chicago, Ill.

1971 OTHERS

Sept. 6–10: *Organ Failure—Lung, Heart, Kidney, Blood, Liver,* American College of Physicians and Royal College of Physicians and Surgeons of Canada, Dalhousie University Faculty of Medicine, Halifax, Novia Scotia. Credit of 28 hours allowed toward AMA "Physician's Recognition Award." Info: Registrar, Postgraduate Courses, ACP, 4200 Pine St., Philadelphia, Pa. 19104.

Sept. 14–18: 22nd Annual Meeting, American Association of Medical Clinics, Sheraton–Cleveland Hotel, Cleveland, Ohio. Info: AAMC, 719 Prince St., Alexandria, Va. 22313.

Sept. 20–24: American Academy of Ophthalmology and Otolaryngology Annual Meeting, Convention Center, Las Vegas, Nev. Info: C. M. Kos, MD, Exec. Sec.–Treas., American Academy of Ophthalmology and Otolaryngology, 15 Second St., S. W., Rochester, Minn. 55901.

Sept. 27–Oct. 1: *Hospital Medical Staff Conference,* University of Colorado School of Medicine, Estes Park.

Sept. 30–Oct. 2: Postgraduate course on *Pediatric Cardiorespiratory Care,* Houston, Tex. Info: Dept. of Continuing Education, American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611.

Oct.: Annual meeting, American College of Emergency Physicians, Miami Beach, Fla. Info: ACEP Headquarters, Arthur E. Auer, Executive Secretary, 120 W. Saginaw, East Lansing, Mich. 48823.

Oct. 5–7: *18th Spinal Cord Injury Conference.* Joint meeting of Veterans Administration Department of Medicine and Surgery and International Medical Society of Paraplegia, Children's Hospital Medical Center, Boston, Mass.

Oct. 8–9: Department of Otolaryngology, University of Miami School of Medicine, *Postgraduate Course in Otolaryngology,* Miami, Fla., Sheraton Four Ambassador Hotel. Info: F. W. Pullen, II, MD, Neuro-Otologic Laboratory, School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Oct. 11–13: Obstetrics and Gynecology Postgraduate Medical Education, Denver, Colo. Info: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Oct. 18–22: 57th Annual Clinical Congress of the American College of Surgeons, Atlantic City, N.J. Info. Sara Barr Cohen, Director of Publicity, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611. Phone: 312/664–4050.

Oct. 20–22: 18th Western Cardiac Conference, University of Colorado Medical Center, Denison Auditorium, Denver. Info: Colorado Heart Assn., 1375 Delaware St., Denver, Colo. 80204.

Oct. 23: American Gastroenterological Association Regional Postgraduate Day at three locations: Pittsburgh, Pa., San Antonio, Tex., and Portland, Ore. Info: Mrs. Francis T. Chalmers, AGA Postgraduate Courses, Box 190, McLean, Va. 22101.

Nov. 8–12: Course in *Occupational Health for Nurses,* Department of Environmental Medicine of New York University School of Medicine in cooperation with American Association of Industrial Nurses. Tuition: $175. Course No. 484. Applications to: Office of Recorder, N. Y. U. Post-Grad. Medical School, 550 First Avenue, New York, N. Y. 10016.

Nov. 9–10: Annual Scientific Meeting, Council on Arteriosclerosis of the American Heart Association, Anaheim, Calif.

Nov. 10–13: Fifth Annual Postgraduate Conference on "Today's Hospital Problems—An Interdisciplinary Approach," Mound Park Hospital Foundation and the College of Medicine University of South Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 11–14: 44th Annual Scientific Sessions, American Heart Association, Convention Center, Anaheim, Calif.

Nov. 15–19: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, P. O. Box 5445, Madison, Wis. 53705)

Nov. 17–19: Annual Conference, National Society for the Prevention of Blindness, Inc., The Roosevelt Hotel, New York City. (Papers, panel discussion and seminars on the latest developments in detecting and combating potentially blinding eye disease, community-action eye health programs, and programs for industrial and school safety.)

1971 AMA

Aug. 29–30: 31st Annual AMA Congress on Occupational Health, Jackson Lake Lodge, Grand Teton National Park, Wyoming. Info: Louis R. Skiera, AMA, 535 N. Dearborn St., Chicago, Ill. 60610.

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

Columbia Hospital Fall Clinic—Milwaukee

Columbia Hospital, Milwaukee, will conduct a fall clinic on the "Solution of the Coronary Dilemma" Tuesday, September 14 from 9 a.m. to 5 p.m. Details of the program appear on page 39 of this issue of WMJ.

Wisconsin Academy of General Practice

The 23rd Annual Scientific Assembly of the WAGP will be held Friday and Saturday, September 10 and 11, at the Hotel Pfister in Milwaukee. Details of the program appear in this issue on page 25.

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Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect; discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

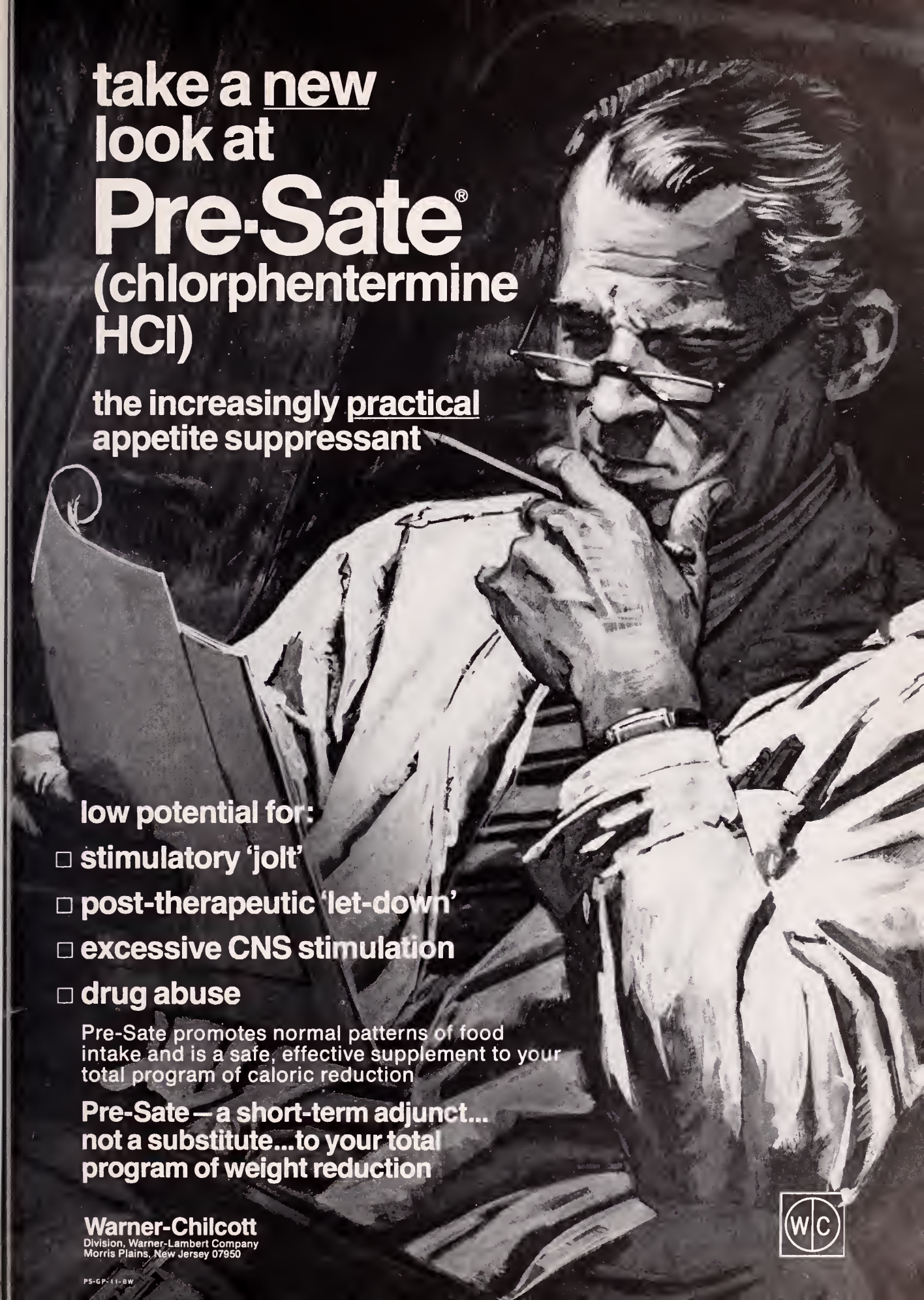
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.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Perinatal Medicine Seminar—Madison

A Perinatal Medicine Seminar will be the central feature of the District VI meeting of the American College of Obstetricians and Gynecologists in Madison on September 30—October 2, at the Loraine Hotel and Park Motor Inn.

The District Nursing Conference will be held in conjunction with the Fellows' meeting for the first time. Seminar sessions will be joint.

Perinatal I on Thursday, "Perinatal Aspects," will have Dr. Leon Mann, Cornell University Medical School, on "Intrauterine Growth Retardation—Physiologic Aspects;" Dr. John R. Esterly, University of Chicago, on "Intrauterine Growth Retardation—Pathologic Aspects;" and Dr. Charles A. White, Jr., University of Iowa School of Medicine, on "Detection and Management of High Risk Pregnancy."

Speakers for Perinatal II, "Neonatal Aspects," on Friday will be Dr. Donald Caton, University of Florida, "Obstetric Anesthesia—Effect on the Newborn;" Dr. John P. Grausz, Medical College of Wisconsin, "Physiologic Changes During the Perinatal Period;" and Estelle Della Pietra, RN, Los Angeles County Hospital, "The Nurse's Role During the Perinatal Period."

On the program for Perinatal III, "Applications of Perinatology in a Community Hospital," Saturday morning are Dr. Richard Zachman, University of Wisconsin Medical School, "The Role of the Pediatrician," and Dr. Roland Hammer, a general practitioner from River Falls, Wisconsin, "The Role of the Generalist."

Yet to be named are two nurses who will appear on Perinatal I and Perinatal III.

Thursday and Friday luncheons also will be combined affairs. Dr. Caton will speak at the luncheon on Thursday. The combined banquet will be Friday evening.

Among ladies' events already planned is a trip on Thursday to Spring Green. It will include a tour through the autumnal Wisconsin River Valley with stops at two antique shops and luncheon in the Spring Green Restaurant, designed by the famous architect, Frank Lloyd Wright.

District VI includes the states of Wisconsin, Minnesota, Iowa, Illinois, Nebraska, South Dakota, North Dakota, and two Canadian Provinces of Saskatchewan and Manitoba.

For advance registration forms (nurses and physicians) write: C. Weir Horswill, MD, FACOG, General Arrangements Chairman, University Hospitals, 1300 University Ave., Madison, Wis. 53706.

Annual Cancer Conference (Scrimmage)—Madison

Madison's 17th annual cancer conference (scrimmage) will be held Saturday, October 16, from 9 a.m. to 12 noon, followed by a luncheon.

Participants will have the opportunity to attend the football game between Michigan State and Wisconsin in the afternoon.

The event is sponsored by the Division of Clinical Oncology, University of Wisconsin Medical Center, and the Wisconsin Division of the American Cancer Society.

Application can be made to Robert J. Samp, MD, University Hospitals, 1300 University Ave., Madison, Wis. 53706.

All state physicians will be receiving a preliminary program prior to the conference.

Interstate Scientific Assembly—New Orleans

The 56th Annual Scientific Assembly of the Interstate Postgraduate Medical Association will be held in New Orleans, La., Nov. 15–19, one extra day from the traditional Assembly program. The extra day provides a special presentation by the Arthritis Foundation with nationally known speakers, and at no increase in fee.

This Assembly is one of the few meetings where closed circuit color TV will be provided, through auspices of Roche Laboratories, with the teaching correlated with patient presentations at Charity Hospital, New Orleans.

Two Wisconsin physicians are on the program: Joseph M. Benforado, MD and Edgar S. Gordon, MD of Madison.

The program is acceptable for 23½ prescribed and 8½ elective hours by the AAGP. It also is accredited by the AMA Council on Medical Education and is acceptable for credit toward the Physicians Recognition Award of the AMA.

Advance registration by Nov. 13 is $25; thereafter, $35. Info: Roy T. Ragatz, IPMA, P. O. Box 5445, Madison, Wis. 53705.

Methodist Hospital Symposium—Minnesota

The 13th Annual Fall Symposium of Methodist Hospital, St. Louis Park, Minn., will be conducted Saturday, September 18, at the Hopkins House Motel in Hopkins.

Entitled "Problems in Primary Practice," the symposium will attempt to cover the whole spectrum of problems which the family or primary practitioner will see in his daily practice.

The symposium will be divided into four sections: (1) What Do Doctors Do?, (2) Workshops in Primary Practice Problems, (3) Delivering Primary Practice, and (4) Family/Youth/Society.

The outstanding faculty includes: Drs. J. A. Malerich, Robert Doan, William Fifer, Jack Hall, Ed Donatelle, Ed Ciriacy, Eldon Berglund, Vince Hunt, Larry Vorlicky, and others.

A dinner and program in the evening will include entertainment by a group of young artists from the Urban Arts program of Minneapolis Schools. The group will present a revue of drama, poetry, and dance, depicting the positive values in the culture of young people in the new world between family and society.

Further info: Harley J. Racer, MD, Symposium Chairman, Methodist Hospital, 6500 Excelsior Blvd., St. Louis Park, Minn. 55426; tel. 929–1313.

Antibiotics and Infection—Iowa

The University Hospitals Department of Internal Medicine of The University of Iowa, Iowa City, will conduct a course on Antibiotics and Infection, October 28–30.

On Saturday afternoon, October 30, Iowa plays Wisconsin at Iowa City in the Big Ten College Football Conference.

Further info: Ian Maclean Smith, MD, Professor of Medicine, University Hospitals, Department of Internal Medicine, The University of Iowa, Iowa City, Ia. 52240; tel. 319/356–2586. □

ADVANCED MATERNITY PROGRAM IN DELIVERY ROOM NURSING
for graduate nurses

Marquette University College of Nursing
Milwaukee

The program is designed for nurses recently employed in hospitals or as a refresher course for those graduate nurses who anticipte returning to work in a maternity department.

Beginning dates: October 11 and November 8, 1971; and January 10, February 7, March 6, and April 17, 1972.

Applicants or inquiries should be directed to Miss Lois Olsen, RN, Marquette University College of Nursing, 3029 North 49th St., Milwaukee, Wis. 53210.

PRESIDENT'S PAGE

Politicians We Aren't!

TRUE, WE ARE PHYSICIANS charged with the health and care of the public. We feel too often that health care is limited to our actual practice of medicine, but total health care goes far beyond this. We must be politically involved in all matters that affect the health of all people.

Our record this year, on the state political scene, has been rather miserable. The passage of the bill authorizing payment of chiropractors under Workmen's Compensation has definitely lowered the quality of care to the public.

At the present time less than 200 doctors are paid-up members of PACE—Professional Association for Civic Education. This means that there are less than 200 of our more than 4,000 members who feel that our political arm is worthwhile. Few doctors will even take time to phone or write their legislators about a vital issue. Is it any wonder that issues are decided contrary to our good judgment?

Recently a state representative bluntly told doctors that "professional organizations don't vote—people do." Then he stated that he had only four doctors write him opposing chiropractic bills. Is it any wonder that the legislators voted as they did?

PACE certainly can't take the place of individual political activity, but we must have a coordinating organization that can educate, inform, and advise local societies. If each county medical society would designate one or more politically interested physician, they could, with a minimum of effort, direct an effective local activity. Funds must be raised and doctors prodded constantly to support political action financially and personally.

On August 1, 1971, the *Wisconsin State Journal* published a report which outlined the political activities of chiropractors in passing the Workmen's Compensation coverage and their plans for passage of insurance and Medicare and Medicaid coverage. This article stated that chiropractors were assessed up to $1,000 each and most devoted a great deal of time and political effort to accomplish their goal. We are all aware of the fact that their success elevates the standing of their cult and has a personal financial benefit to them.

If we as physicians would only contribute a minimum of financial support and devote a few minutes of time each month to political issues, we could greatly improve our political standing.

Let us as physicians with the help of our wives get behind PACE and develop an effective political stance throughout the State of Wisconsin.

G. A. Behnke M.D.

G. A. BEHNKE, MD

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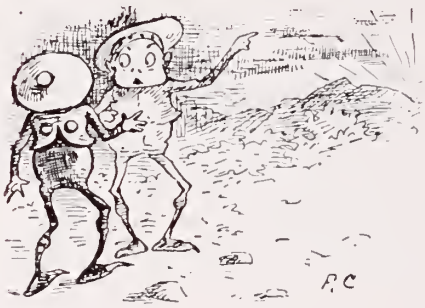
EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

Mirror, Mirror Upon the Wall . . .



For the first twenty-five years that I taught medical students and graduate students, I saw reflections of myself as a youngster. The questions were often ingenious and searching, but the essence of their inquiry fell well within the system I knew and accepted. Indeed I only vaguely realized that there were other systems, except in faraway lands.

In the last five years there has been a remarkable change. Perhaps it is a change upon the land; certainly it is a change on the campus and decidedly a change in the medical school.

In the Medical College of Wisconsin, formerly Marquette School of Medicine, forty of the graduating seniors sought and obtained public forum for their statements of what Medicine has been, what it is, and what it should be. These same students began thinking and talking this way right from their first freshman medical class.

The reflection of myself has been broken in the last half-decade. The new breed of students asks questions that cannot be answered from textbooks. To hold their interest, even in freshman psychiatry, I have had to bring in social psychologists and even some debating (and debatable) sociologists. Those issues which appeared clear in the past have now become clouded with welfare notions and with bitter remonstrations because large segments of our population receive absolutely no medical care while other smaller groups receive some sort of public, hospital-type care and a much smaller segment receives royal treatment.

Nor are these forty young doctors the only reflections of troubled images shooting back from the mirror of ourselves. After all, these forty sought the podium of a standard medical school commencement ceremony. Even a worse image of ourselves can be seen in the growing rift between the political public and physicians. All the proposed plans for delivery of medical services move us further from the individual responsibility model, for ourselves and our patients. There remains only a matter of degree, and how fast, and who determines the form that medical service will take in the very near future. Even our syntax seems incapable of holding fast to our present system or of extolling any of its possible virtues.

We seem caught in a kind of "me too, but I can do it better" system. A further rift within physician ranks does not help us decide whether the picture we see of ourselves in the mirror is indeed the fairest one of all. And if we do not think so, who else will—the public, the allied professions, the politicians?

Thus, in New York State since January of this year when it became possible for the first time, nearly one third of the state medical society members dropped their AMA memberships while holding state and local affiliation. Not to be outdone, the AMA now offers direct memberships without state affiliation to interns, residents, and VA physicians. While it is not entirely clear why these changes are occurring, they seem to evolve from political rather than medical issues. Violent charges are hurled and small, sly comments are dropped in the "right" places, but the schism continues.

What are some of the issues our own "sons" raise right here in Wisconsin? They charge that the AMA is monolithic in its insistence on holding to the present system of medical practice *and* that this sytem totally fails to accord services for minorities and for the poor. They do not question the quality of care the busy practitioner gives his small band of loyal patients, and they do not doubt that he sometimes, or oftentimes, gives his services for nothing to the few aggressive poor who ask for them. Their challenge is that the doctor seems too busy or too preoccupied with his precise system of hospital hierarchy and his office practice details to open his eyes—like the little men in the illustration—to the horizon and there to see the need about him.

They extend their inquiry further by citing the fact that two percent of the population controls 80 percent of the wealth with which they can purchase their own medical care and other goodies while at the same time remain untouched by and aloof to the needs of the middle and lower classes. They feel that it is "un-American" for 27 million of us to live below poverty level and for even larger segments of the middle class to be placed in double jeopardy of simultaneous physical and financial hardship because of the fee-for-service system at the point of a major medical emergency.

For some years now several branches of Medicine have been off the fee-for-service system. Psychiatrists, except for shock treatment and turnstile tranquilizer practices, are paid privately and by the private insurance companies *by the minute*. Hours of service are defined as "fifty minutes," no less. Some doctors of internal medicine when charging for an initial physical examination use the "hour" unit for payment of a fee-for-time rather than the complained about fee-for-service. Surgeons remain apart generally and up to now from the fee-for-time arrangement, being paid in nearly all systems by the operational unit; that is, fee for *service* performed. However, they now realize that what happens to their colleagues can happen to them.

But what about the other side of the mirror—the ability of the patient to pay? One can easily say that this has nothing to do with the science of Medicine, and perhaps it does not. But these are the issues which nearly half of the graduating class demanded be brought before its own faculty and its own community: full medical care, based on prepayment and doctors to be on salaries; funds for the service to come from the public, but drawn from the two percent of wealthy persons, and no longer considered a private responsibility. Anything less, they state, is "un-American" because it fails to provide physical security from which the other American ideals can be sought.

Another major point that these young doctors make is that ninety percent of the graduating classes from the medical schools are white, middle class males. Neither racial groups nor the distaff population are represented. They ask why this is so. They are not satisfied with the answer that it has always been so, and that anyway, "we" take care of women in our private practices and blacks in our half day at county hospital.

It is ever so important that we convey to the admittedly heterogeneous medical population of Wisconsin the precise nature of the complaints of our own new doctors. The issues spelled out here will be ever more rapidly returning to us from the mirrors within our profession as well as without. It really is not enough to go busily on our way, no matter how competent we are or how righteous we feel. We need three things, as the years roll on. One, we need precise statements and not hysterical distortions of the issues involved between ourselves and between ourselves and the interested public. Two, we need effective, not plaintive, public relations. What we do have to offer is not inconsiderable, either in conception or service; yet, we have failed badly to transmit that fact to the general public, although individual, satisfied patients may appreciate us. Because we have failed to convey our worth to the general public, either through pompous declarations of worth or excess defensiveness, small groups with rigorous and radical views have effectively touched large segments of the reading and viewing public. Three, we seriously lack and must address ourselves to political issues. True, we may now and then write a letter to or treat medically one of the lawmakers; as a body we even issue statements about various issues and testify before appropriate legislative committees. However, results have been sad. Even in such fundamental issues as chiropractic, we do not seem able to counter effectively their lobby for witness the resultant surge of partisan legislation that is upon us. How much more effort would be required for the larger issues?

Watch this space for further attempts in all three areas. With Pope, I hope that the little pictures will "for the page atone."—RH □

SPECIAL TO THE JOURNAL

"Monster" Moves to State Medical Society

By Mildred Schroeder
DeForest, Wisconsin

JOHN McDONALD GRINDE, MD, a dynamo of energy from DeForest, has outdone himself again. He recently created what may be the largest known medical emblem, a caduceus, as a retirement gift to a close and special friend, Charles H. Crownhart.

The steel sculpture, over six feet tall and weighing nearly 200 pounds, is on display in the lobby of the State Medical Society of Wisconsin headquarters, 330 East Lakeside Street, Madison.

Mr. Crownhart, who retired January 1 as secretary and general manager of the Society after 29 years of service, remains in the capacity of a consultant. As a hobby, Mr. Crownhart has acquired from all over the nation a large collection of caducei (Aesculapian staffs), which he has cherished over the years. The emblem has been reproduced in a variety of ways, including handwork such as embroidery, knitting, tatting, and crocheting. Some are made of buttons or coins and other items on various backgrounds. The emblems were given to him by doctors' wives, his family and friends, and acquaintances from all over the State of Wisconsin.

"Doctor Grinde's creation is the largest one I've ever seen, and the only one of welded steel," Mr. Crownhart enthused. It was a complete (and delightful) surprise. Sharing the surprise with Doctor Grinde was Terrance S. Goerne, administrative assistant of the State Medical Society's Charitable, Educational and Scientific Foundation whose many projects include the Aesculapian Staff Collection. Doctor Grinde consulted with Mr. Goerne on a number of occasions during the sculpture's creation. The first Mr. Crownhart knew about it was when a special delivery letter arrived at his office with a photo of the nearly finished caduceus and a note stating: "The monster will be delivered to Mr. Crownhart upon completion."

Mr. Crownhart advised Doctor Grinde not to deliver the gift right away. Instead he and Earl Thayer, his successor at the Society, traveled to DeForest to view the sculpture and to tour the world-famous barns of the American Breeders Service, Inc.

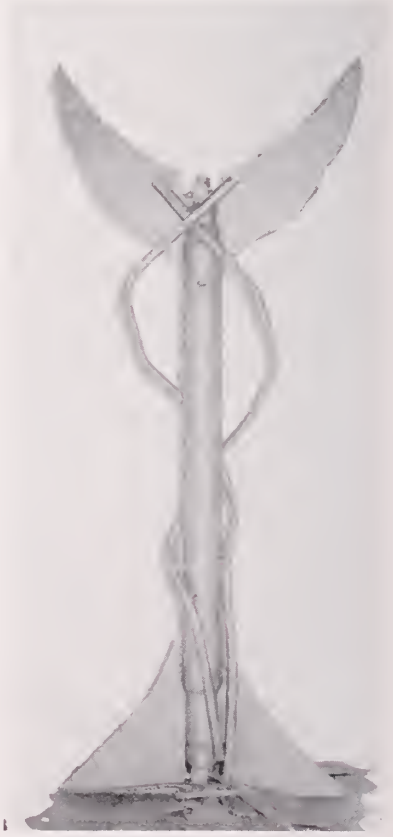
Doctor Grinde said he felt a desire to create a "monster of steel" the first time he saw Mr. Crownhart's collection. "My only certainty was to size," he said, "I wanted it to be huge and grotesque, large enough to be a caricature, to express the humor."

He had never done welding until about 1967 when he bought an $18.00 outfit, not even a good toy. But it made him love the welder's torch and he took a few lessons. He didn't know much when he started the project, but he said, "I definitely had a desire to do something to show my respect and gratitude to Mr. Crownhart . . . to me he is a great man, and nearly every member of the profession agrees."

One day Doctor Grinde read about Mr. Crownhart's imminent retirement in the Society's official publication—the *Wisconsin Medical Journal*. That's what set the wheels in motion. "I knew I had to move fast, and turned on all my burners," he said in his usual colorful fashion. Although it was one of the coldest days in history, it seemed as if the whole town got caught up in the spirit of Doctor Grinde's enthusiasm. Friends and patients came to watch the developments and pitched in to help. The sculpture was nearly completed on the day it was started. Work went on until 3:10 in the morning. "It wasn't too long before everyone in town became caduceus-conscious," one of the merchants mused.

Clifford Koch, a mechanic—and a "genius"—helped Doctor Grinde retrieve from the snow the drive shaft from the doctor's old Cadillac which had been saved for the monster. They followed a suggestion from Mike Paulson, a contractor, that rods from the old DeForest water tower be used as serpents in the sculpture. Doctor Grinde liked the idea of using materials connected with the community. "Besides, this has a personal connection with me, as I used to play around the tower when I was a kid," he said.

It wasn't long before an audience had assembled at Warren Loveland's Body Shop, where the welding had begun. One of the bystanders, Richard Radcliffe, a University of Wisconsin art student from Massachusetts and fiancé of a granddaughter of Dr. E. P. Carlton, Nancy Wenger of Portage, commented: "I just love coming to DeForest—there's always so much action going on." Miss Adeline Lyster, a colorful local resident,



"Here is Caduceus,
The monster, made of
Sandblast, torch and ice
And sweat and love and iron."

By JOHN M. GRINDE, MD

said: "It was an impromptu, old-fashioned get-together, and lots of fun." Doctor Grinde, Gerald Bowen, Mr. Loveland and Mr. Koch labored until 3:00 a.m., then took their creation to the doctor's reception room.

The next day Doctor Grinde enlisted the aid of a woman patient to phone for information about finding a sandblaster. While the doctor was on another phone arranging for a truck for transporting the monster, the woman and her older daughter, Shirley Zimmerman, loaded it into the trunk of their Buick and were off to Madison to have it sandblasted.

Doctor Grinde was so moved by this transaction that it motivated him to continue his article titled, "The Superiority of Females over Males in the Biological Kingdom," and that same night, strangely enough, he dreamed of the proper ending for the article as well as the solution for the final base of the caduceus.

Another patient, Gerhard Stubkjaer, a long-time friend of the Grindes, agreed to transport it back from the city—so the odyssey of the monster continued, and at one point it was displayed in the yard of the Grinde home, with lights floodlighting it at night. One resident said, "It must be the most traveled trophy in the world."

Doctor Grinde has expressed deep appreciation to the people who assisted him with this project, and to those who provided moral support. "It was unbelievable," he remarked. A giant in mind and heart, Doctor Grinde is a man of unlimited drive and is interested in many hobbies, including poetry and writing. He has discovered an enjoyment in the heating, shaping, and bending of metals. "I'm just wild about welding," he said.

In discussing the CES Foundation's hobby projects, Mr. Goerne says: "Hobbies encourage people of all ages to participate in the world around them." Congressman Robert Kastenmeier wrote, after an article about Doctor Grinde's hobbies appeared in the *Wisconsin State Journal:* "It sounds as if it would be worth being sick just to pay a visit to your office. Your interest in mental health and your sense of humor go hand in hand, certainly humor can help at a trying time."

And now that the sculptured caduceus, the steel monster created for Charles Crownhart, has left DeForest to take its place in the world, it seems to the townspeople that something is missing. People are wondering now, what will Doctor Grinde think of next? □

23RD ANNUAL SCIENTIFIC ASSEMBLY

Wisconsin Academy of General Practice

Friday–Saturday, September 10–11
HOTEL PFISTER, MILWAUKEE

The 23rd annual scientific assembly of the Wisconsin Academy of General Practice will be held Friday and Saturday, September 10–11, at the Pfister Hotel in Milwaukee.

Over 500 physicians are expected to attend the two-day program, which offers 12 hours of prescribed credit for AAGP members. All physicians are invited to attend.

Scientific sessions, featuring 18 guest speakers, will be held all day Friday and Saturday afternoon. Saturday morning will be devoted to a meeting of the Congress of Delegates, the policy making body of the organization, representing 18 chapters in the state. There are 875 members of the Academy in Wisconsin.

The featured speaker at the Friday luncheon will be Dr. Jerome Wildgen, Kalispell, Montana, who is president-elect of the 30,000 member parent organization, the American Academy of General Practice.

Dr. Paul E. Wainscott, Menasha, will be installed as president of the state group at the Saturday luncheon, succeeding Dr. George V. Murphy, South Milwaukee.

Highlights of the meeting will include reports on the family practice training programs around the country, including those at the University of Wisconsin and at St. Michael's Hospital in Milwaukee. There also will be a special report on physicians' assistants training programs.

The complete program follows:

Friday, September 10

9:00 am	Pediatric Immunology, Richard Hong, MD, Madison
9:30 am	Neonatal Care, Richard Zachman, MD, Madison
10:00 am	GYN Malignancies, John Hurley, MD, Milwaukee
11:00 am	Family Medicine Programs in the U.S., Robert E. Rakel, MD, University of Iowa
11:30 am	Family Medicine Program at St. Michael's, Norbert G. Bauch, MD, Milwaukee
12:00 n	Luncheon: Special report from Dr. Jerome Wildgren, President-elect of the AAGP
2:00 pm	Transvenous Pacing and Arrhythmias, Richard Duchelle, MD and Thomas Puchner, MD, Milwaukee
3:00 pm	L-Dopa Therapy, Gastone G. Celesia, MD, Madison
4:00 pm	The Hyperkinetic Child, Frederick Blodgett, MD, Milwaukee
6:00 pm	Oyster and Keg Party

Saturday, September 11

9:00 am	Congress of Delegates meeting
12:00 n	Luncheon: Installation of officers
2:00 pm	The Physician and Ecology, Mr. Robert J. Schneider, Chicago, Ill.
2:45 pm	The Role of the Physician Assistant, Mr. Robert Paine, Marshfield
3:30 pm	Kidney Donor Problems, H. Myron Kaufmann, MD, Milwaukee
4:00 pm	Hyperlipidemia in Diabetes, Manuel Tzagournis, MD, Columbus, Ohio
4:30 pm	Osteoporosis, Mark Mueller, MD, Madison
6:00 pm	Presidents' Reception

SECTION OPHTHALMOLOGY

AUGUST 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

WISCONSIN–UPPER MICHIGAN SOCIETY OF O–O

The Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology will meet at Lake Delton, October 9 and 10. Dwain E. Mings, MD of Monroe, Society president, will preside at the meeting.

An ophthalmologist from the University of Vienna, Austria, Karl Ossoinig, MD, will be the guest speaker. Doctor Ossoinig has been using ultra-sound for many years to diagnose lesions of the eyeball and orbit. On Saturday afternoon, October 9, he will give a short discussion of the basic theory of ultra-sound and then follow with a talk on the practical clinical applications of ultra-sound in diagnosis of lesions of the eye and especially of the orbit.

There will be a dinner Saturday evening, October 9, after which Doctor Ossoinig will describe the life of an Austrian ophthalmologist under socialized medicine. On Sunday morning, October 10, there will be an informal breakfast and discussion with Doctor Ossoinig. The breakfast discussion will be followed by a business meeting.

Ophthalmologists who are not members of this Society but who wish to attend may obtain more information by writing the Wisconsin-Upper Michigan Society of O & O, Eye Clinic, University Hospitals, Madison, Wis. 53706.

(An October date was picked this year so that it would not conflict with the American Academy of Ophthalmology and Otolaryngology meeting in September and with University of Wisconsin home football games.)

RESIDENTS GO INTO PRACTICE

On July 1 four residents completed their residency in ophthalmology at the Medical College of Wisconsin in Milwaukee.

Kenneth S. Fabric, MD has become associated with MDs Anton S. Dorn, Ralph E. Teitgen, and Raymond C. Warner in Milwaukee.

Gene J. Pawlowski, MD is practicing in California at the Southern California Permanente Hospital, Los Angeles.

Vincent P. Savaglio, MD has begun a private practice in Kenosha.

Thomas R. Stevens, MD has begun a one-year fellowship at the Proctor Foundation of the University of California Medical Center in San Francisco.

WISCONSIN LIONS EYE BANK

The Eye Bank Committee of the Wisconsin Lions Foundation received recently the following report from the Milwaukee and Madison headquarters of the Eye Banks for the first three months of 1971.

The Madison Eye Bank headquarters received 31 eyes. These eyes were used in the following manner: corneal transplant, 6; research, 22; preserved sclera, 1; and practice surgery, 2.

The Milwaukee Eye Bank received 36 eyes. These were used in the following manner: corneal transplant, 8; research, 24; and corneal preservation, 4.

The eyes that were used for research were rejected by the surgeons for one or more of the following reasons: age of donor, delay in getting permission to remove the eyes, cause of death, unavailability of recipient, or personal reasons of the surgeon.

The Wisconsin Lions Foundation of the Wisconsin Lions Clubs will be supporting the operation of the Eye Banks in Wisconsin this coming year with a $15,000 gift.

EYE INSTITUTE IN MILWAUKEE

Derward Lepley, Jr., MD, alumni fund chairman, recently announced to alumni of the Medical College of Wisconsin a fund-raising campaign.

The Medical College of Wisconsin Board of Directors plans to raise $13.9 million in the campaign which began July 1 and continues to June 30, 1975. The money will be used for: operations, $2.6 million; basic science building, $9.1 million; and Eye Institute, $2.2 million.

The MCW Eye Institute is an exciting concept that is expected to be funded in large part by gifts from individuals and organizations with specific interests in problems of ophthalmology. The estimated cost of the Eye Institute is $2.8 million, of which $600,000 has already been pledged leaving $2.2 million remaining to be raised by the fund-raising campaign of the alumni group.

The eight-story Eye Institute will be physically attached to the northeast corner of Milwaukee County General Hospital and will serve purposes unique in the Midwest.

RETINAL DETACHMENT ARTICLE PUBLISHED

This issue of the *Wisconsin Medical Journal* carries a scientific article on "Retinal Detachment" by Matthew D. Davis, MD. It appears as the "Comments on Treatment" feature starting on page 190.

NEWS HIGHLIGHTS

Dr. Broderick Surprised at Farewell

Over 400 friends, relatives, former patients, and colleagues of C. F. Broderick, MD,* Wisconsin Dells, held a surprise party for him June 13. Dr. Broderick has retired from practice following major heart surgery in January. He and his wife have sold their Wisconsin Dells home and are moving to Arizona.

Dr. Broderick has practiced in the Dells since 1946, following his discharge from World War II Navy service. That year he joined the late John H. Houghton, MD in opening a clinic there. Frederick W. Gissal, MD, joined the clinic the following year. Dr. Gissal was the main speaker at the program, and former Lt. Gov. Jack Olson served as master of ceremonies.

The program included presentation of gifts and testimonials from the community. A huge banner reading "Thank You Dr. Broderick" hung over the entrance of the Chula Vista Resort where the event was held.

Dr. Broderick has been a member of the State Medical Society's Commission on Public Policy since 1963 and its vice-chairman since 1966.

Elected to Kidney Foundation

MDs David Hathaway,* Neenah, and Arvin Weinstein,* Madison, recently were elected president and vice-president, respectively, to the Board of Directors of the Kidney Foundation of Wisconsin, Inc., affiliate of the National Kidney Foundation of Wisconsin.

New Fellows Elected to ACP

The following physicians recently were granted fellowships in the American College of Physicians: MDs George P. Nichols,* Appleton; William L. Deardorff,* Elm Grove; Robert H. Caplan,* La Crosse; Robert F. Barreras, and Derek J. Cripps, Madison; and Glenn H. Franke,* Kiesl K. Kaufman,* and David Y. Rosenzweig, of Milwaukee.

Doctor and Mrs. Broderick at farewell event. (Photo courtesy WISCONSIN DELLS EVENT)

PHYSICIAN BRIEFS

Samuel J. Faber, MD*

. . . Racine, retired June 15. A general practitioner, Doctor Faber was the 50th president of the Racine County Medical Society in 1955. He is a graduate of Rush Medical School. He will reside in Los Angeles, Calif.

Martin L. Janssen, MD*

. . . Arthur R. Weihe, MD* of the Adams County Memorial Hospital and the Roche-a-Cri Clinic, Friendship, recently were named diplomates of the American Board of Family Practice.

Waclaw Olejnik, MD

. . . Grantsburg, recently joined the medical staff at Bayfield County Memorial Hospital, Washburn. A general practitioner and surgeon, he also has joined the Memorial Clinic staff with MDs John Telford* and Harry Larson.*

Masaud A. Farooq, MD

. . . Waupun, recently opened his practice in the Waupun Clinic. Doctor Farooq, a native of India, completed his education in India and came to the United States in 1959. He resided in St. Paul, Minn., Louisville, Ky., and Peoria, Ill., before going to Minneapolis where he practiced medicine for four years. Doctor Farooq came to Waupun from Cook, Minn.

H. Laurence Burdick, MD*

. . . Milton, recently received the Pillar of Milton award at the Milton Alumni Association banquet. The award was begun in 1946 and Doctor Burdick is the 27th alumnus to be honored. He has been the Health Services physician at the College for a number of years. He has served as president of the Rock County Medical Society and is a graduate of the University of Wisconsin Medical School.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Frederick A. Fosdal, MD*

. . . on July 1 began a private practice in general and forensic psychiatry in Doctors' Park, Madison. Doctor Fosdal just completed a one-year fellowship in forensic psychiatry, Department of Psychiatry, University of Wisconsin Medical School. He is a 1964 graduate of the UW Medical School. His internship was served in the USPHS Hospital, San Francisco, Calif., after which he completed a three-year residency in psychiatry at the UW Medical School. Dr. Fosdal also served three years in the US Army in psychiatry.

Richard L. Pyle, MD*

. . . has been appointed clinical director of Mendota State Hospital, Madison. He had been director of adult services at Mendota this past year. For six years Doctor Pyle had served as clinical director at Central State Hospital, Waupun, and for two years as chief of psychiatry at the USPHS Hospital, Lexington, Ky.

Paul B. Mason, MD*

. . . Sheboygan, was honored by the Wisconsin Heart Association when it presented him a medallion in recognition of his contribution to the association's founding. The presentation occurred during the WHA's 25th annual meeting in Milwaukee in May.

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CONTRIBUTIONS—CES FOUNDATION

May 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support.

The Foundation wishes to acknowledge the following contributions for May 1971:

Nonrestricted

State Medical Society Members ---------- Voluntary contributions of 114 MDs
Massachusetts Mutual Life Ins. Co. ------ Dividend
L. O. Simenstad, MD, J. W. McRoberts, MD. Woman's Auxiliary to the La Crosse County Medical Society, Sylvia Graf Foundation, Inc. ---------- Contributions
Dr. and Mrs. W. D. James ---------- Memorials: Charles H. Nehls, Mrs. Roland Kienast, George W. Myers
Wisconsin Physicians Service ---------- Memorial: Karl Doege, MD
State Medical Society ---------- Memorials: Helen J. Zillmer, MD. C. W. Harper, MD, C. E. Kampine, MD, E. C. Howell, MD, J. H. May, MD, J. J. Robb, MD

Museum of Medical Progress

State Medical Society Members ---------- Voluntary contributions of 1 MD
Prairie du Chien Federal Savings & Loan, Mississippi River Rats, Wis. Chap. Assn.-- Ecology Exposition

Student Loans

State Medical Society Members ---------- Voluntary contributions of 16 MDs
Wisconsin Physicians Service ---------- Contribution

Charitable—Disabled Physicians

State Medical Society Members ---------- Voluntary contributions of 16 MDs

Scientific Teaching

State Medical Society Members ---------- Voluntary contributions of 4 MDs

Other Than CESF Projects

State Medical Society Members ---------- Voluntary contributions of 15 MDS

Danforth Memorial Student Loan Fund

Mrs. Quincy H. Danforth ---------- Contribution

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD ---------- Contribution

Charles H. Crownhart State Student Loan Fund

Woman's Auxiliary to the State Medical Society of Wisconsin ---------- Contribution

Tormey Memorial Fund

T. W. Tormey, MD ---------- Contribution

Freshman Medical Student Summer Externship Program

Thomas S. Westcott, MD, St. Croix Falls Clinic, John S. Honish, MD ---------- Contributions

CONTRIBUTIONS FOR JUNE 1971

Nonrestricted

State Medical Society Members ---------- Voluntary contributions of 30 MDs
Gene P. Wegner, MD ---------- Contribution
Robert G. Zach, MD ---------- Contribution

Barbara & Howard Brower, Dr. & Mrs. Frederick H. Wolf, Dr. & Mrs. E. J. Nordby, Wm. Cremer Family, W. T. Casper, MD, Skemp & Grandview Clinic, Mr. & Mrs. Arthur E. Hebberd, Dr. & Mrs. Charles Skemp, David N. Goldstein, MD, LeRoy & Mary Gagermeier, Ruth M. Dalton, MD, Mrs. F. E. Yerly, Dr. & Mrs. David Morris, Gunnar Gundersen, MD, Leona K. Chesemore, Women Employees of the La Crosse Clinic, Mr. & Mrs. Frederick Funk, Rose M. Ehrlich, Dr. & Mrs. H. J. Kief, Mr. & Mrs. Fredric Crosby, Dr. & Mrs. Geo. B. Ellenz, Fred Manget, Miss Frieda Kube, Judge & Mrs. Peter G. Pappas,

continued on next page

William S. Middleton, MD Awarded Honorary Degree

William S. Middleton, MD,* Madison, was awarded the honorary degree of Doctor of Science at UW commencement ceremonies in June. Doctor Middleton retired as dean of the University of Wisconsin Medical School in 1955, and later served as chief medical officer of the Veterans Administration for eight years.

Named to Health Councils

Two physicians have been reappointed for three-year terms to separate councils of the State Division of Health.

N. A. Hill, MD* of Madison was reappointed to the Council on Nursing Homes, representing medicine.

R. E. Housner, MD* of Richland Center was reappointed to the Council on Hospital Construction, representing physicians.

Both terms expire July 1, 1974.

CES FOUNDATION CONTRIBUTIONS *continued*

Leif H. Lokvam, MD, R. S. Galgano, MD, Robert B. Murphy, Richard & Lois Duxbury, WPS–Internal Audit Department of State Medical Society, Mr. & Mrs. Wayne Hood, W. E. Wright, MD, Dr. & Mrs. E. D. Sorenson, Gundersen Clinic, Dr. & Mrs. Roman E. Galasinski, Mr. & Mrs. R. J. Anderson, Mr. & Mrs. Jon R. Bogie, Dr. & Mrs. Ubaldo Alvarez, Dr. & Mrs. W. D. James, Hi Hope Investment Club, Mr. & Mrs. John Elliott, Frederick & Adeline Pederson, F. E. Drew, MD, Mr. & Mrs. Lewis J. Dedo, Dr. & Mrs. C. J. Picard, Dr. & Mrs. Leonard W. Schrank, W. J. Brown, Mr. & Mrs. Joseph E. Ludden, Mr. & Mrs. William E. Meyer, Joan Pyre, Dr. & Mrs. DeWitt C. Beebe, Walton R. Manz, MD, Mr. & Mrs. George C. Nixon, Dr. & Mrs. Gordon J. Schulz, Dr. & Mrs. J. Wm. Boren, Jr., N. A. Hill, MD, State Medical Society	Memorial: James C. Fox, MD
State Medical Society	Memorial: William G. Healy, MD
N. A. Hill, MD	Memorial: Fletcher Wellemeyer
Dr. & Mrs. J. Wm. Boren, Jr.	Memorial: Mrs. August Haller
Margaret K. Pharo	Memorial: Mrs. M. A. Jacobson
Dr. & Mrs. Gordon J. Schulz	Memorial: Mr. Arnold Engelke
Elmer B. Sandeen & Wisconsin Physicians Service	Memorial: Florence Pollock
Dr. & Mrs. E. D. Sorenson	Memorial: Russell Miller, MD
Dr. & Mrs. C. J. Picard	Memorial: Charles Stoops, MD
Dr. & Mrs. Leonard W. Schrank	Memorial: Ted W. Patterson
Student Loans	
State Medical Society Members	Voluntary contributions of 2 MDs
Dr. & Mrs. Paul Dietz	Memorial: James C. Fox, MD
Other Than CESF Projects	
State Medical Society Members	Voluntary contribution of 1 MD
Danforth Memorial Student Loan Fund	
Mrs. Quincy H. Danforth	Contribution
Tormey Memorial Fund	
Marguerite A. Cordts	Contribution
Charles H. Crownhart State Student Loan Fund	
The Sheboygan Clinic Foundation	Contribution
W. W. Hildebrand Memorial Account	
William B. Hildebrand, MD	Contribution
J. G. Crownhart Memorial Account	
C. H. Crownhart	Memorials: James C. Fox, MD Charles J. Baumann, DDS
Barbara Scott Maroney Memorial Fund for Research on Diabetes	
H. B. Maroney	Memorial: James C. Fox, MD
Medical Student Summer Externship Program	
Surgical Care–Blue Shield, R. M. Hammer, MD, E. P. Rohde, MD, J. G. Albright, MD, J. E. McKenna, MD, T. C. Fox, MD, D. V. Blink, MD, J. O. Moermond, Jr., MD, L. W. Weisbrod, MD, Donald Welter, MD, Dale Moen, MD, G. Zauft, MD, P. Bishop, MD, H. Carlson, MD, Gerald C. Kempthorne, MD, Wm. R. Marquis, MD, T. Walsh, MD, I. Galarnyk, MD, Kenneth L. Strebe, MD, John Peters, MD, Charles J. Picard, MD, C. J. Strang, MD, Ronald Logemann, MD, J. T. Siebert, MD, David Downs, MD, Leonard Torkelson, MD, R. Shropshire, MD, Arthur Weihe, MD, Martin Janssen, MD, Norman Schroeder, MD, Nathan Davis, MD, D. J. Schroeder, Jr., MD, Trinity Memorial Hospital—Cudahy, Wisconsin Physicians Service, Jack K. Reinold, MD, F. M. Bannister, MD	Contributions

Oscar E. Hanson, Jr., MD*

. . . Fort Atkinson physician since 1933 and pioneer of programs for alcoholics in Jefferson County, recently was awarded the Lions Club's 1971 Distinguished Community Service Award. Doctor Hanson is a graduate of the University of Wisconsin Medical School.

John H. Randall, MD

. . . Green Bay, recently was named to the Advisory Committee on Drug Abuse by the State Board of Health and Social Services. He has been a board member of the People's Drug Abuse Center. The committee, composed of 15 members, will survey and evaluate the program for state drug abuse services and will advise the Department of Health and Social Services on its long-range policies and goals.

George A. Hellmuth, MD*

. . . Hartford, recently was presented the Citation for Meritorious Service on behalf of the President's Committee on Employment of the Handicapped. Doctor Hellmuth is director of the Cardiac Work Classification Unit of the Curative Workshop Adult Rehabilitation Center, Medical College of Wisconsin, Milwaukee.

Edward B. Miner, MD*

. . . specialist in internal medicine at the Gundersen Clinic, La Crosse, recently was appointed United Fund campaign chairman to head the professional division in this year's United Fund campaign. Doctor Miner served with the United States Health Service in Washington, D. C. before joining the Gundersen Clinic in 1964.

Trygve Gundersen, MD

. . . Boston, brother of four La Crosse physicians, is president-elect of the American Ophthalmological Society and recently was elected to the Academy of Medicine in Rome. He is professor and chairman of the ophthalmology department at Boston University School of Medicine. Currently taking shape at the Boston Medical Center is the Gundersen Eye Clinic named for Doctor Gundersen who is associated with the center.

John G. Jaeger, MD

Max M. Smith, MD

John G. Jaeger, MD*

. . . La Crosse, recently became associated with the Gundersen Clinic, Ltd., and Lutheran Hospital in the Department of Anesthesiology. He graduated from the University of Wisconsin Medical School in 1967 and served his internship at the Gundersen Clinic. Doctor Jaeger's residency training was at the Mayo Clinic, Rochester, and the University of Wisconsin Medical School, Madison. Prior to his appointment at the Clinic, he had served a one-year fellowship in pediatric anesthesiology at the Children's Hospital Medical Center in Boston.

Max M. Smith, MD*

. . . Madison, recently was appointed an adviser to St. Mary's Medical Center, Madison. Doctor Smith, a member of the medical staff of St. Mary's since 1953, is serving his second term as chief of staff. He is a founder and past president of the Wisconsin Psychiatric Association.

Djuro Obradovic, MD

. . . Tomah, recently joined the medical staff of the Tomah Veterans Administration Hospital. He served in the U. S. Army Medical Corps in France and was in private practice in Youngstown, Ohio, before joining the Veterans Hospital.

Ayaz M. Samadani, MD

. . . Cambria, recently became associated with the Cambria Clinic. He graduated from Sind University, West Pakistan, in 1964, worked as a ship's surgeon for a year, then traveled to London, England where he spent five years in postgraduate training. He has completed residencies in Internal Medicine and Pediatrics. He will be associated with the Beaver Dam hospitals.

Director Named to Medical Center for SE Wisconsin

Robert R. Cadmus, MD of Morristown, N.J., has been named the new executive director of the Medical Center for Southeastern Wisconsin. Dr. Cadmus comes to Wisconsin from the presidency of the College of Medicine and Dentistry of New Jersey at Newark.

Announcement of the appointment was made by Delwin C. Jacobus, chairman of the Medical Center Council of Southeastern Wisconsin, a group of citizens and representatives of health care institutions from southeastern Wisconsin, which has been planning the Medical Center.

The hiring of a full-time executive director and administrative staff was made possible by a recent $150,000 grant from the Faye McBeath Foundation, Mr. Jacobus said. The grant will be paid over three years in $50,000 installments annually starting this year.

In announcing the appointment, Mr. Jacobus said, "We are most fortunate to obtain a man of Dr. Cadmus' qualifications to head the Medical Center at this critical stage in its development. His unique combination of experience as a physician, researcher, teacher, and administrator makes him highly qualified to be chief executive officer of a project as complex and as large in scope as this."

The concept of the Medical Center for Southeastern Wisconsin has been under intensive study for several years. A master plan for the Center, developed after almost two years of study, was outlined recently before the Milwaukee County Welfare Board. The MCSW is designed to serve the needs of the population in a number of counties in southeastern Wisconsin.

Among the facilities involved are Milwaukee Children's Hospital; Froedtert Memorial Lutheran Hospital; Milwaukee Psychiatric Hospital; the Milwaukee County Institutions; Veterans Administration Hospital at Wood; Curative Workshop and the Milwaukee Blood Center.

The Medical College of Wisconsin and Marquette University have been participants in planning for the Medical Center. The proposed Eye Institute recently announced by the Medical College will be an important facility of the Center in the future.

Construction and development of facilities on the county site of the "geographic" members of the Medical Center complex is designed to proceed over a period of twenty years. Funds for such construction would come from private sources as well as state and federal governments, Mr. Jacobus stated.

R. R. Cadmus, MD

N. G. Bauch, MD

St. Michael Hospital, Milwaukee, Starts Family Practice Program

St. Michael Hospital, Milwaukee, recently established a family practice unit and offers a three-year residency in the new medical specialty of Family Practice.

The new unit will be known as the St. Michael Family Care Center and is located on hospital property, but will be an independently operating facility.

Norbert G. Bauch, MD,* Milwaukee, past president of the Wisconsin Academy of General Practice, has been named director of the Family Care Center. He is a 1945 graduate of Marquette University School of Medicine (now Medical College of Wisconsin) and has been on the medical staff of the hospital since 1949. Doctor Bauch was chief of the General Practice department and had served on the hospital's resident-intern committee since 1948. He recently ended a 15-year term as chairman of the committee.

Dr. Emanuel Heads WHA

Dean A. Emanuel, MD* of Marshfield took office as president of the Wisconsin Heart Association at its 25th anniversary meeting in Milwaukee this spring.

John H. Morledge, MD* of Madison is the newly elected president-elect and will take over the presidency next May.

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Governor's New State Health Council Meets

There were lots of questions and few answers at the first meeting of the 39-member State Health Policy and Program Council appointed by Governor Lucey in May.

Most of the questions were of the type a new employee might ask his first day on the job: What should I do? How should I do it? Where are the files?

Most of the Council members are new to the job, which is a vast one. They must act as an advisory board to five state health agencies which have federal funding. These are: comprehensive health planning, developmental disabilities, hospital construction, mental health centers construction, and facilities for the mentally retarded. All of these programs are administered by the State Department of Health and Social Services.

The direction that the Council's work must take was set by Council chairman Ben R. Lawton, MD, of Marshfield. He noted that the Council is not starting in a vacuum, but "will build on the great work that has been done in Wisconsin in health by so many." He emphasized that the new Council "doesn't want to threaten anyone; it wants to help all."

The Council's vice-chairman, industrialist David Carley of Madison, linked the Council's work with that of the Governor's new Health Planning and Policy Task Force which Mr. Carley heads. He noted that the Task Force has been asked to build a comprehensive plan. That plan will have to be carried out in part by the Council.

Mr. Carley said, "Health care is a political issue, but health is not a partisan matter. Government has a responsibility in health care and cannot stand outside it."

The "new employees" that make up the Council include 17 health providers—six physicians, three hospital and clinic administrators, two nurses, three government officials, and four representatives of private associations—and 22 consumers of health services. The latter are drawn from business, labor, health associations, and minority groups.

One of the most urgent questions asked at the first meeting was whether the Council meets federal requirements for advisory boards to the five health areas. For example, it was unclear if advisors on developmental disabilities should include consumers of care for mental retardation, cerebral palsy, and epilepsy.

The Council replaces the State Advisory Council for Comprehensive Health Planning, and ten of the members have been carried over from that group. All of the members serve at the pleasure of the Governor.

Physicians and their representatives on the new Council include: Ben R. Lawton, MD, Council chairman; Peter L. Eichman, MD, Madison; John S. Hirschboeck, MD, Milwaukee; Gerald A. Kerrigan, MD, Milwaukee; John W. Maxwell, Jr., MD, Milwaukee; William R. Merchant, MD, Madison; and Earl R. Thayer, Madison.

Dr. Callan Renamed to Council on Health

A former president of the State Medical Society has been reappointed to the Council on Health.

Robert E. Callan, MD of Milwaukee was reappointed in July by Gov. Patrick J. Lucey. Dr. Callan had been appointed in 1970 by Governor Knowles to fill the unexpired term of Frank E. Drew, MD, who resigned.

The term is for seven years. The Council on Health is an advisory group within the State Department of Health and Social Services.

MEMBERS' HELP NEEDED

Within the next 30 days, all State Society members will be receiving a professional liability insurance survey. A prompt return of the completed form is essential. Responses to the survey will be used by the Society's Committee on Economic Medicine and the Council as a basis for negotiations with insurers for a membership group protection plan.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

Wisconsin Legislative Roundup

The following is a listing of the key bills and their status as of July 17, 1971. (A denotes Assembly bill, S denotes Senate bill.) Further information on other bills and an updating of status will appear periodically in the GREEN SHEET, in legislative bulletins, and in special communication to officers of county societies.

Bill	*Subject*	*Current Status*
14, A.	ABORTION—introduced by Representative Barbee. Would remove abortions from the Statutes dealing with crimes. SMS has taken no position on any specific abortion legislation, because the question is currently being considered by the courts. Other bills on abortion include 600, A., 722, A. and 723, A.	Assembly Judiciary has recommended indefinite postponement
53, A.	CHIROPRACTIC—AUTO LIABILITY INSURANCE POLICIES. Requires all auto liability insurance policies to provide medical payments coverage, and by Senator Knutson amendment, chiropractic treatment coverage. SMS OPPOSES in present form.	Passed both Senate and Assembly and is on the Governor's desk. SMS has requested veto
206, A.	GENERIC PRESCRIBING—introduced by over 40 Representatives. Would require physicians to prescribe by generic name and also require labeling by generic name. SMS OPPOSES.	Public hearing held by Assembly Committee on Health and Social Services
304, A.	DEPARTMENT OF REGULATION AND LICENSING—introduced by Representatives Atkinson and Boeckman. Would place the Department of Regulation and Licensing under the direction of a Regulation and Licensing Board. SMS OPPOSES in present form.	Assembly Committee on State Affairs has recommended indefinite postponement. Referred to Joint Committee on Finance
307, A.	BLOOD TESTS. Would require that, under the implied consent law, the state would assume civil liability for negligent performance in drawing blood by physicians, persons under their direction or employers of persons drawing blood. SMS position is that physicians should not be relieved of negligent acts but should not be liable for correct withdrawing of blood as required by the implied consent statutes.	Public hearing held by Assembly Judiciary Committee
367, A.	AMBULANCE LICENSING AND REGULATION. Provides for the licensing and regulation of ambulance service managers and ambulance attendants. SMS SUPPORTS on basis of action taken on this subject by the House. Amendments being considered to assure that no area of the state is left without emergency transportation services.	Referred to the Joint Committee on Finance

continued on next page

Drs. Albright, Dessloch Elected to Society Posts

Two physicians were elected to fill vacant State Medical Society posts at the July 31 meeting in Madison of the Society's Council.

Edwin C. Albright, MD, of Madison, was chosen co-editor of the "Comments on Treatment" page of the *Wisconsin Medical Journal.* E. M. Dessloch, MD, of Prairie du Chien, was elected to an unexpired term as an alternate delegate to the American Medical Association's (AMA) House of Delegates.

Dr. Albright holds the editorship with Richard I. H. Wang, PhD, MD, a professor of clinical pharmacology at the Medical College of Wisconsin, Milwaukee. "Comments on Treatment" has been a continuous *Wisconsin Medical Journal* feature since 1938. Through it, physicians in the larger hospitals and medical centers can pass on to the practicing physicians in the state the results of research and clinical efforts in diagnosis and treatment. The "CT Page" has long been a significant factor in the continuing education of state physicians.

Dr. Albright is professor of medicine at the University of Wisconsin Medical School and the current president of the Dane County Medical Society. He succeeds Ovid O. Meyer, MD, emeritus professor of medicine, UW Medical School.

Dr. Dessloch was elected to the position left vacant by the death of La Crosse physician James C. Fox, MD. He is alternate to J. M. Bell, MD, of Marinette, and Dr. Dessloch's term runs through 1972.

Dr. Dessloch

Dr. Albright

AMA delegates represent state physicians at the two yearly national AMA conventions. There is one AMA delegate for every 1,000 members of the AMA in the state. Wisconsin has five delegates and five alternates.

Dr. Dessloch is also chairman of the Medical Society's Commission on Medical Care Plans. He is in private practice in Prairie du Chien.

Narcotics Registration Deadline Extended Again

The Bureau of Narcotics and Dangerous Drugs (BNDD) has extended its July 29 deadline for use of physician registration numbers under the Controlled Substances Act to October 1, 1971.

The BNDD regional office address is: Engineering Bldg., Suite 1700, 205 W. Wacker Dr., Chicago, Ill. 60606.

422, A.	SAFETY GLASSES. Requires students and teachers in certain academic classes to wear safety glasses. SMS SUPPORTS.	Assembly Education Committee has recommended passage and the Assembly has adopted a Substitute Amendment which has been referred to Joint Committee on Finance
482, A.	FAMILY PLANNING. Would provide for removal of contraceptives from statutory list of indecent articles. SMS SUPPORTS other family planning legislation (see Senate Bills 2 and 130), but has not taken a formal position on 482, A.	On Assembly calendar
495, A.	LICENSED OCCUPATIONS—introduced by Representative Barbee. Would repeal the educational requirements for hearing aid dealers and fitters as well as other licensed trades. SMS OPPOSES.	Indefinite postponement recommended by Assembly Committee on State Affairs; laid on the table by the Senate
500, A.	INSURANCE FOR TB PATIENTS. Would require that every health insurance contract would have to cover TB charges and would alter the state aid formula to county tuberculosis sanatoriums. SMS SUPPORTS aid to county sanatorium, but OPPOSES mandatory inclusion of benefits in health insurance policies. Bill 501, A. would also make insurance coverage mandatory.	Referred to Joint Committee on Finance
519, A.	FAMILY PLANNING—introduced by Representative Conta. Would repeal the Statutes which prohibit the advertising or display of indecent articles intended to procure a miscarriage or prevent pregnancy and which prohibit sale of such to unmarried person. SMS supports family planning, but has taken no position on this bill (see Senate Bills 2 and 130).	Hearing held by Assembly Health and Social Services Committee
521, A.	MEDICAL INTERNSHIPS. Would provide that no hospital could require an examination other than an examination required by the Medical Examining Board or one given by the hospital for selection purposes as a condition to being admitted to an internship. SMS OPPOSES this proposal because it would lessen present standards.	Indefinite postponement recommended by Assembly Health and Social Services Committee
634, A.	MEDICAL INTERNSHIP. Would permit a particular individual to be admitted to internship in any hospital in Wisconsin without further examination. SMS OPPOSES individual bills such as this and feels the Medical Practice Act is sufficiently liberal to allow all qualified practitioners to be fairly dealt with.	Public hearing by Assembly Education Committee
707, A.	PHYSICIAN'S ASSISTANT. Provides that the Medical Examining Board shall establish standards for certifying individuals who hold themselves out as physician's assistants. SMS INTRODUCED AND SUPPORTS THIS LEGISLATION including Substitute Amendment 1 which was introduced in cooperation with the Legislative Council. SMS OPPOSES other amendments.	Passage recommended by Assembly State Affairs Committee; referred to Joint Committee on Finance
2, S.	FAMILY PLANNING—introduced by Senator Soik (R-Whitefish Bay). Would remove contraceptives from the list of indecent articles and enable sale by physician or pharmacist. Sale would be restricted to those over age 18 except under certain circumstances. SMS SUPPORTS with amendment to remove age limitations.	Withdrawn from Senate Health and Social Services Committee and referred to calendar
32, S.	COMPREHENSIVE PLANNING BY COUNTIES. SMS SUPPORTED to extent that bill would allow county boards to contribute funds for planning, but favored retaining coordinating control in the State Division of Health.	Passed—Chapter No. 48
51, S.	RECODIFICATION OF THE MENTAL HEALTH STATUTES—introduced by the Wisconsin Legislative Council. SMS SUPPORTS with amendment to provide that no commitment procedure shall be complete without such commitment being certified by a physician.	Passage recommended by Senate Health and Social Services Committee and referred to Joint Committee on Finance
55, S.	JOINT SURVEY COMMITTEE ON LICENSING—introduced by the Legislative Council. SMS SUPPORTS the concept but not in form proposed by this legislation.	On Senate calendar
93, S.	PERMITS MUNICIPALITIES TO BUILD MEDICAL CENTERS—introduced by Senator Lorge. SMS DOES NOT ACTIVELY OPPOSE this legislation but does not feel that it will adequately help alleviate the health manpower shortage.	Senate has passed, but Assembly nonconcurred
130, S.	FAMILY PLANNING—introduced by Senator Risser (D-Madison). Would remove contraceptives from the list of indecent articles and allow physician to provide family planning information. SMS SUPPORTS.	Indefinitely postponed
144, S.	SAFETY EYE GLASSES—introduced by Senators Soik (R-Whitefish Bay), Devitt (R-Milwaukee), Steinhilber (R-Oshkosh) and Murphy (R-Waukesha). Would require that students in certain academic classes such as chemistry and industrial arts, etc., wear safety glasses. SMS SUPPORTS.	Referred to Joint Committee on Finance

continued on next page

160, S.	CONSENT FOR MEDICAL TREATMENT BY MINORS—introduced by Senators Keppler (R-Sheboygan) and Risser (D-Madison). Would permit minors to be treated with or without parent's consent for health care which, if denied would be a significant hazard to the health of the patient and to the public. SMS SUPPORTS such legislation ONLY to the extent that it permits treatment of VD without parental consent.	Indefinitely postponed and reconsideration refused
202, S.	CHIROPRACTIC AND PRIVATE HEALTH INSURERS—introduced by Senate Committee on Health and Social Services. Would make it mandatory for private health insurance plans to provide coverage for chiropractic services. SMS OPPOSES.	Public hearing held by Senate Health and Social Services Committee
203, S.	CHIROPRACTIC SERVICES UNDER MEDICAID (TITLE 19)—introduced by Senate Committee on Health and Social Services. Would require payment for chiropractic under Medicaid. SMS OPPOSES.	Public hearing held by Senate Health and Social Services Committee
204, S.	CHIROPRACTIC TREATMENT UNDER WORKMEN'S COMPENSATION—introduced by Senate Committee on Health and Social Services. Would require payment for chiropractic treatment under Workmen's Compensation. SMS OPPOSED.	Passed—Chapter No. 61
238, S.	PODIATRY—introduced by 17 Senators and 15 Representatives. This bill would give podiatrists the unrestricted right to use narcotic drugs and allow them to amputate toes. SMS OPPOSES unless educational qualifications are demonstrated by podiatrists.	Passed Assembly and Senate. Sent to Governor on July 20
255, S.	MEDICAL EDUCATION—introduced by Senators Lorge, Chilsen and Devitt. Would create funds for medical education by increasing tax on cigarettes. SMS SUPPORTS aid to medical schools but has stated that before a third medical school is established, both the University of Wisconsin Medical School and the Medical College of Wisconsin should be increased in size and have adequate funding. ALSO AMENDED TO PROVIDE FOR CERTIFICATION OF PHYSICIAN'S ASSISTANT WHICH SMS SUPPORTS. SMS OPPOSES OTHER AMENDMENTS WHICH WOULD NEGATE EFFECTIVENESS OF PHYSICIAN'S ASSISTANTS.	On Senate calendar
259, S.	DISPENSING OPTICIANS EXAMINING COUNCIL—introduced by the Committee on Governmental Affairs. SMS SUPPORTS the creation of a dispensing opticians examining council under the Medical Examining Board.	Referred to Joint Committee on Finance
297, S.	TRANSFUSION LIABILITY—introduced by Senate Committee on Health and Social Services. Would provide that a person would not be liable for damages occurring in procuring, processing or distribution of blood or blood products. SMS SUPPORTS.	Passed Senate and referred to Assembly Judiciary Committee
419, S.	DISTINGUISHED VISITING MEDICAL PROFESSORS—introduced by Senators Murphy, Chilsen, Devitt and Lorge. Would permit the Medical Examining Board to issue a temporary license to practice medicine, for a period of up to six years, for a graduate of a foreign medical school who is a visiting professor at a Wisconsin medical school. SMS SUPPORTS.	Passed Senate and referred to Assembly Health and Social Services Committee
Senate Joint Res. 38	MEDICAL EXAMINER SYSTEM. Would permit a county or group of counties to create a medical examiner system in lieu of the office of coroner. SMS SUPPORTS.	Passed by Senate and now under consideration by Assembly
452, S.	MEDICAL TRANSPLANT LIABILITY. Would provide that no hospital, physician, nurse or other medical personnel, acting under the supervision of a physician involved in procuring, processing or distributing human tissue or organs for transplanting, shall be liable for damages resulting therefrom except for his own negligence. SMS SUPPORTS.	Passed by the Senate and referred to Assembly Committee on Judiciary
463, S.	PHYSICIAN'S ASSISTANTS—introduced by the Legislative Council and Senators Lorge and Chilsen. Would create councils on medical and health education and establish mechanisms for certifying physician's assistants. SMS SUPPORTS SUBSTITUTE AMENDMENT I BUT DOES NOT SUPPORT OTHER AMENDMENT ATTEMPTS WHICH WOULD NEGATE THE EFFECTIVENESS OF THE PHYSICIAN'S ASSISTANT.	Senate Education Committee recommended passage of Substitute Amendment 1 and bill has been referred to Joint Committee on Finance
593, S.	KIDNEY DISEASE AID. Proposes to establish a program of state aid to supplement the cost of kidney disease treatment. A board would be created to supervise patients and treatment centers. SMS SUPPORTS THE PRINCIPLE, BUT FEELS THIS WOULD BE BETTER HANDLED AS CATASTROPHIC CARE UNDER INSURANCE RATHER THAN BY STATE FINANCING.	Senate Health and Social Services Committee recommended passage of Substitute Amendment 1
597, S.	PERINATAL HEALTH COUNCILS. Would create a perinatal health care authority and regional councils within the state. SMS DOES NOT SUPPORT LEGISLATIVE APPROACH, but favors educational programs designed to improve the quality of care of expectant mothers and newborn infants.	Passage recommended by Senate Health and Social Services Committee. Referred to Joint Committee on Finance

Dr. Kincaid Retires As Madison Health Director

Turtles with salmonella, the dangers of skateboards, red measles, plastic ice cubes, air and water pollution—these have been a few of Dr. Charles K. Kincaid's concerns during his 23 years as Madison Director of Public Health.

Dr. Kincaid, 63, retired at the end of June. He was honored at a swirl of local farewell parties and in tributes by two groups with which he had worked closely. At its June meeting the Dane County Medical Society, which Dr. Kincaid headed in 1966–67, presented him with a certificate in appreciation of his long dedication to the profession. On June 15 the Madison City Council passed a resolution taking "official recognition of the outstanding work of Dr. Kincaid as Director of Public Health for the period 1948 to July 1, 1971."

Dr. Kincaid

Trading Wisconsin's snowy winters for warmer Alabama ones, Dr. Kincaid and his wife Elin have sold their Madison home and moved to Mobile, where Mrs. Kincaid once lived.

Madison newspapers quoted Dr. Kincaid as saying that he was looking forward to fishing and hunting turkey and quail in his new home. He also said he would spend some of his retirement time "meditating on how to motivate people to do something that's good for them." Trying to discover the secret of this motivation has been one of his main concerns since becoming a physician 36 years ago.

Dr. Kincaid has been in public health since 1937, when he took his first position with the Indiana State Board of Health. Before coming to Madison, he served as city–county health officer in Eau Claire, in the Army Medical Corps in Europe during World War II, and as health officer in Will County, Ill.

Until Dr. Kincaid's successor is chosen, Madison's acting health officer is Thayer W. Burnham, city biochemist and director of the city health department's laboratory.

While city health director, Dr. Kincaid became a member of many professional societies. In addition to serving as president and trustee of the Dane County Medical Society, he served two terms as president of the Wisconsin Public Health Association and was president of the Wisconsin Health Council (1963–64) and of the Wisconsin School Health Council (1964–65). He is a fellow of the American College of Preventive Medicine and a member of the American Association of Public Health Physicians, American Public Health Association, Wisconsin Anti-Tuberculosis Association, and the State and American medical societies.

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Conversion from the High Risk to the Low Risk Category

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Structured Rehabilitation After Infarction

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ROBERT A. BRUCE, M.D.
Professor of Medicine
Co-Director Div. of Cardiology
University of Washington, Seattle

DAVID M. BERKSON, M.D.
Assoc. Professor of Medicine
Northwestern University — School of Medicine, Chicago, Ill.

IRVING HEINLY PAGE, M.D.
Director (Emeritus) of Research in Cardiovascular Disease
Cleveland Clinic Foundation
Cleveland, Ohio

SEPTEMBER 14 9:00 am.-5:00 pm.

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Earl Jochimsen, MD*

. . . Sheboygan, was reappointed for a second three-year term as a member of the Wisconsin Council on Community Mental Health Center. Doctor Jochimsen is a director on the board of the Wisconsin Association for Mental Health, a member of the governing board, and past treasurer of the Wisconsin Psychiatric Association. He is a graduate of the University of Wisconsin Medical School.

Sidney Shindell, MD*

. . . Bayside, has been elected vice-chairman of the statewide Citizen Study Committee on Metropolitan Problems. Doctor Shindell is chairman of the Division of Preventive Medicine at the Medical College of Wisconsin, Milwaukee.

Neal S. Simons, MD*

. . . Whitehall, recently had the new Whitehall Clinic dedicated to him. Doctor Simons, who retired from active practice in 1966, had practiced in the Whitehall area for more than 50 years and was instrumental in establishing a medical era in Whitehall.

Dr. Meyer UW Teaching Chair Assured

A $100,000 pledge from the Oscar Rennebohm Foundation towards creation of an Ovid O. Meyer, MD* clinical teaching chair in the Department of Medicine at the University of Wisconsin was announced recently.

Over 60 fellow medical school faculty members and friends honoring the now retired professor of medicine in ceremonies at the Madison Club were told that the teaching chair will be supported for at least five years. In addition to the $100,000 Rennebohm Foundation pledge another $30,000 has been received from patients, fellow faculty members, medical alumni, and friends.

Dr. Meyer retired as emeritus professor from the medical school June 30 after 40 years of treating patients at University Hospitals and teaching medical students.

Internationally known for his research in hematology, Dr. Meyer is recognized as an expert on lymph node diseases and a world authority on the use of anticoagulants.

La Crosse Clinic Joins Medical Clinics Group

The Skemp–Grandview Clinic in La Crosse has been elected to membership in the American Association of Medical Clinics. The Skemp–Grandview Clinic, a multispecialty group practice, was founded Oct. 1, 1969, under the Wisconsin Service Corporation statute. The Clinic represents a union of two separate clinics which had been in existence for many years. The professional staff consists of 18 full-time physicians representing the following specialties: general surgery, urology, internal medicine, ob-gyn, ophthalmology, pediatrics, and general practice.

Madison General Hosp. Cited

Madison General Hospital in Madison was honored for 50 years of membership in the American Hospital Association at its 73rd Annual Convention, August 23–26, in Chicago.

The hospital will receive a plaque lauding "dedication to community services and its half century of continuing support and participation toward our mutual goal of providing better hospital care for all the people." Gordon N. Johnsen is the hospital administrator.

TENTATIVE SCHEDULE—ORTHOPEDIC FIELD CLINICS

July 1, 1971—December 31, 1971

STATE DEPARTMENT OF PUBLIC INSTRUCTION

DIVISION FOR HANDICAPPED CHILDREN—BUREAU FOR CRIPPLED CHILDREN

MADISON, WISCONSIN 53702

Location	*Date*	*Location*	*Date*
Stevens Point	August 18	Superior	October 5
Ashland	August 26 and 27	Racine	September 23 and October 13
Manitowoc	September 8 and 9	Kenosha	October 20 and 21
La Crosse	September 15 and 16	Sheboygan	October 27 and 28
Eau Claire	September 20	Rhinelander	November 3 and 4
Chippewa Falls	September 21		

FOR: Clinics conducted by the Bureau for Crippled Children of the Division for Handicapped Children are for persons under 21 years of age who are referred by their family physician for orthopedic diagnosis and consultation. Reports of the examinations are sent to the referring physician following clinic.

REFERRAL FORMS: Referral forms may be obtained from the Division for Handicapped Children and should be requested well in advance of the clinic date. Medical referral forms are made up for each clinic so when requesting same be sure to state how many forms are needed and for which clinic. It is important that we know well in advance the number desiring clinic service so the case load will not exceed clinic facilities.

CLINIC APPOINTMENT: Families who return the signed referral forms will be notified of the date and hour of their appointment a few days before the clinic. Parents and physicians are invited to attend the clinic.

ADDRESS CORRESPONDENCE: Division for Handicapped Children, 126 Langdon Street, Madison, Wisconsin 53702.

Dr. D. R. Korst is Named Assistant Medical Dean, UW

Donald R. Korst, MD,* Madison, an associate professor of medicine, has been named assistant dean for educational administration at the University of Wisconsin Medical School by Dean Peter L. Eichman.*

Dr. Korst, who is coordinator for extramural programs in the UW department of medicine as well as director of education in internal medicine at Madison General Hospital, will serve as assistant dean in addition to his other duties. He will work in the area of student affairs and curriculum in the administrative position.

D. R. Korst, MD

A 1948 graduate of the UW Medical School, Dr. Korst is an internist and a specialist in hematology and nuclear medicine. He practiced in Ann Arbor, Mich., for five years and served on the University of Michigan Medical School faculty from 1954–65 before joining UW's department of medicine.

Dr. Korst is a fellow in the American College of Physicians. He interned at the University of Pennsylvania after receiving his MD from Wisconsin, served his residency at University Hospitals in Madison and also was a fellow in medicine and hematology at UW.

Eau Claire Anesthesiologists Join Medical Clinics Group

The Eau Claire Anesthesiologists, Ltd., Eau Claire, has been elected to membership in the American Association of Medical Clinics. The Eau Claire Clinic, a single specialty group, originated in 1956 by Harry E. Thimke, MD,* who later was joined by MDs R. O. Bjurstrom* and Walter M. Kelley,* and incorporated as Thime, Bjurstrom and Kelley, S.C. in 1961. Additional physicians joined the group and in 1970 the corporate name was changed to the present title. The Clinic currently is composed of five full-time physicians, all certified in anesthesiology.

Henry A. Anderson, MD*
. . . former medical director of the River Pines Sanatorium, Whiting, near Stevens Point, since 1941, has moved to Madison where he is now chief medical consultant with the Bureau of Social Security Disability of the State Division of Vocational Rehabilitation. The sanatorium, one of Wisconsin's pioneer tuberculosis hospitals, recently was sold to Mid-American nursing homes.

Dean B. Becker, Jr., MD*
Roger I. Bender, MD*
. . . Oshkosh and Beaver Dam, respectively, recently were elected to three-year terms on the board of directors of the University of Wisconsin Medical School Alumni Association. Doctor Becker also has been granted a fellowship in the American College of Physicians.

Roland R. Liebenow, MD*
. . . Lake Mills, recently was reelected chairman of the Board of Directors of Marquardt Memorial Manor, Watertown. It is a skilled nursing care center which opened in July 1969.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
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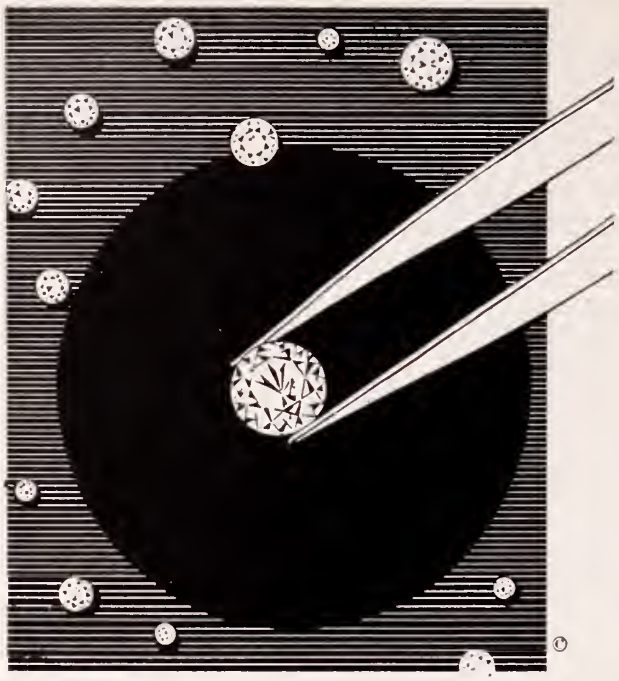

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Paul R. Glunz, MD*

. . . Beaver Dam pathologist, recently was appointed to the State Health and Social Services Board. He has been active in comprehensive health planning the past two years and is chairman of the Jefferson County Comprehensive Health Planning Committee. He also is a member of the board of directors of the Health Planning Council, Inc., Madison, which covers an 11-county area.

Harry Beckman, MD*

. . . Milwaukee, was awarded the Distinguished Service Citation at the Medical College of Wisconsin's commencement ceremonies this spring. Doctor Beckman is MCW's emeritus professor of pharmacology and was chairman of the department from 1926 to 1962 when he semi-retired. He then became a consultant to Columbia Hospital until July 1 when he completed his retirement plans by moving to "our little home in New Hampshire." He plans to continue writing, however, in a "more relaxed way." Doctor Beckman's reprints, monographs, and other medical literature which he has collected since the early 1920s were recently placed in the Columbia Hospital Reprint Library. He also was the Columbia Hospital librarian.

Hugh J. McLane, MD*

. . . Fond du Lac, received a silver platter during the 25th anniversary meeting of the Wisconsin Heart Association when it met in May in Milwaukee. He was honored for his past-presidency served in 1966–67. Doctor McLane retired from the association's board of directors and was given a certificate for meritorious service.

Kenneth M. Sachtjen, MD*

. . . Madison orthopedic surgeon, on August 25–28 will direct a training course on emergency care and transportation of the sick and injured in cooperation with the University of Wisconsin Medical Center and the American Academy of Orthopaedic Surgeons who are sponsoring the four-day course of lectures and practice demonstrations for ambulance attendants, nurses, firemen, police officers, and others.

Dr. Mohs Presents Paper on Facial Chemosurgery

Frederic E. Mohs, MD,* Madison, recently presented a paper entitled "Chemosurgery for Facial Neoplasms" at the seventh annual scientific meeting of the American Academy of Facial Plastic and Reconstructive Surgery, Inc., held in San Francisco.

Dr. Mohs is head of the Chemosurgery Clinic of the University of Wisconsin Medical Center and clinical professor of surgery at the University of Wisconsin Medical School, Madison. □

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JULY 1971

6 Dane County Medical Society Board of Trustees
6 Dane County Medical Society
8 Board of Directors, Wisconsin Association of Professions
10 SMS Commission on Medical Care Plans
10 Advisory Committee on Utilization Review Programs
12 Dane County Medical Society Utilization Review Plan
12 Dane County Medical Society Sports Medicine Committee
14 SMS Commission on Health Information
16 Wisconsin Nutritional Council
16 SMS Commission on Scientific Medicine
17 Dedication of Old Military Road Map (Prairie du Chien)
20 Professional Nurse Registration Exams
21 Professional Nurse Registration Exams
22 Professional Nurse Registration Exams
23 Professional Nurse Registration Exams
27 Dane County Medical Society Sports Medicine Committee
28 Dane County Medical Society Board of Censors
30 Seminar on Occupational Health
30 Executive Committee of SMS Council
31 Finance Committee of SMS Council
31 Committee on Economic Medicine of SMS Council
31 AMA Delegates Caucus
31 SMS Council

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF JUNE 1971

1 Madison General Hospital Surgical Staff
1 Madison Urological Society
1 Madison Anesthesiology Soc.
1 Dane County Medical Society Board of Trustees
1 Dane County Medical Society Sports Medicine Committee
4 Madison Society of Obstetrics and Gynecology
9 SMS Commission on Public Policy
9 Legislative Committee, Wisconsin Assoc. of Professions
9 Regional Perinatal Care Program of Madison
11 MEDIHC Operating Comm.
12 SMS Commission on Scientific Medicine
13 SMS Medical Awards Ceremony and President's Reception
14 Dane County Medical Society Insurance Advisory Comm.
16 Wisconsin Regional Medical Program Staff
20 SMS Division on Nervous and Mental Diseases (Marshfield)
23 Dane County Medical Society Board of Censors
26 Executive Committee of SMS Council
28 Dane County Medical Society Prepaid Group Practice Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

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William R. Maurer, Jr., MD

. . . Harrington Park, N. J., recently became associated with Lewis Jacobson, MD,* Eagle River. Doctor Maurer, a board qualified surgeon, graduated from the Cornell University Medical School and interned at Bellevue Hospital, New York. During World War II, he served as a member of the paratrooper corps and earned his glider wings. He was promoted to Division Rear Surgeon in charge of an active jumping medical company. After the war, he received further training at Cornell and was an instructor in the department of pathology and set up the first cancer detection clinic for the Department of Health and Public Health Services in New York. He also was a member of a selected group of surgeons who served a four-year progressive surgical residency at the Bronx VA Hospital in New York. Doctor Maurer was with the Closter Medical Group for eight years and also was chief of surgery at Englewood Hospital in New Jersey.

Ernest A. Pellegrino, MD*

. . . Madison, recently joined George H. Vogt, MD* in the practice of orthopedic surgery. Doctor Pellegrino graduated from the University of Wisconsin Medical School, interned at George Washington University Medical Center, and served his residency at the University of Wisconsin Medical Center. He recently was released from the United States Air Force.

Stuart E. Adair, MD*

. . . DePere, J. Michael Hartigan, MD,* La Crosse, and Kathryn P. Nichol, MD, Madison, recently were elected to fellowship in the American Academy of Pediatrics.

Jack Ficke, MD

. . . Menomonie, recently became associated with the Red Cedar Clinic, Menomonie. Doctor Ficke graduated from the University of Minnesota Medical School in 1965 and interned at Marine Hospital, Staten Island, N. Y. He spent two years with the U. S. Public Health Service in Gallup, N. M., and three years in residency training at the University of Mississippi, Jackson. □

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Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.

Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.

Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.

Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.

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CORRECTION to Previously Published Article:

"Early Radiology in Wisconsin" in February 1971 issue of WMJ

The medical history feature on "Early Radiology in Wisconsin" by J. E. Habbe, MD of Milwaukee, which appeared in the February 1971 issue of the Wisconsin Medical Journal, page 34, contained an error which the Journal editors wish to correct.

The third paragraph from the end of the article, which started out: Dr. Roy Potter . . .. should have read as follows:

Dr. Roy Potter (1879–1968), one of the six founder members of the Marshfield Clinic, had his radiologic training from his radiologist brother, Hollis, in Chicago. Doctor Roy was one of the first presidents of the Section.

Dr. William T. Clark (1882–1970) of Janesville, combined an office practice of radiology with both radiology and anesthesiology at Mercy Hospital. He also served many years on the State Board of Health, and was its president from 1960 to 1965.

Our apologies to Doctor Habbe whose original copy was correct.

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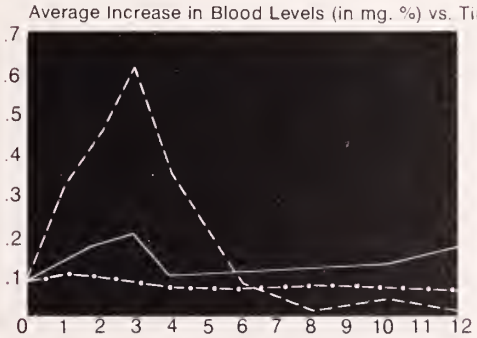

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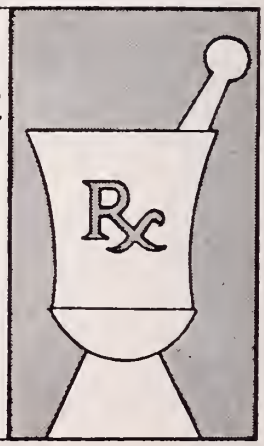

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1971 WISCONSIN

Sept. 30–Oct. 2: District VI Meeting of American College of Obstetricians and Gynecologists and Nurses Conferences, Loraine Hotel & Park Motor Inn, Madison.

Oct. 2–3: Symposium on Medical Education, Medical College of Wisconsin, Pioneer Inn, Oshkosh.

Oct. 15–16: Annual Fall Meeting, Wisconsin Society of Obstetrics and Gynecology, The Abbey, Fontana (Lake Geneva).

Oct. 16: Seventeenth Annual Fall Cancer Conference (scrimmage), Division of Clinical Oncology, University of Wisconsin Medical Center, Madison and Wis. Division of American Cancer Society. Info: Robert J. Samp, MD, University Hospitals, Madison, Wis. 53706.

Oct. 17–23: Wisconsin Work Week of Health.

Oct. 22: Wisconsin Orthopedic Society, Veterans Administration Hospital. Barry Friedman, MD, Cleveland, Ohio, guest speaker. Further info: James M. Huffer, MD, 1300 University Ave., University Hospitals, Madison, Wis. 53706.

Oct. 23: Fall Meeting, Wisconsin Society of Pathologists, VA Hospital, Madison. Key speaker at seminar on Pulmonary Pathology: John P. Wyatt, MD, University of Manitoba, Canada.

Oct. 23: Annual Congress, Wisconsin Association of Professions, Pioneer Inn, Oshkosh.

Oct. 30: Wisconsin Dermatological Society, Wood Veterans Administration Hospital, Milwaukee.

Nov. 20: Annual Meeting, Wisconsin Chapter, American College of Surgeons, St. Joseph's Hospital, Milwaukee.

1971 NEIGHBORING STATES

Oct. 3–8: Annual meeting, Michigan State Medical Society, Grand Rapids.

Oct. 4–9: Postgraduate course in Laryngology and Broncho esophagology, Department of Otolaryngology of the University of Illinois at the Medical Center, University of Illinois Eye and Ear Infirmary, Chicago, Ill.

Oct. 8: Annual Meeting of Association of American Physicians and Surgeons, Colony Motor Hotel, Clayton, Mo. Info: AAPS, 230 N. Michigan, Chicago, Ill. 60601.

Oct. 10: Joint scientific meeting, American College of Preventive Medicine and Association of Teachers of Preventive Medicine, Hotel Leamington, Minneapolis, Minn.

Oct. 10–15: 14th Annual Meeting, American Society of Clinical Hypnosis, Pick Congress Hotel, Chicago, Ill. Info: F. D. Nowlin, Exec. Secy., 800 Washington Ave., Southeast, Minneapolis, Minn. 55414.

Oct. 13: Symposium on Hypertension & Chronic Renal Failure, Kidney Foundation of Illinois, Sheraton–Chicago Hotel, Chicago.

Oct. 16–21: American Academy of Pediatrics 40th Annual Meeting, Palmer House Hotel, Chicago, Ill. Info: Department of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

Oct. 23–29: Annual Otolaryngologic Assembly of 1971, University of Illinois Hospital Eye and Ear Infirmary, Chicago, Ill.

Oct. 28–30: *Antibiotics and Infection Course,* University of Iowa, Iowa City.

Nov. 1–3: Mayo Clinic Clinical Reviews, Mayo Civic Aud., Rochester, Minn. Credit of 26 hours by The American Academy of General Practice and the College of Family Physicians of Canada. Info: Postgraduate Courses, Mayo Clinic–Mayo Foundation, Rochester, Minn. 55901.

Nov. 8–10: Mayo Clinic Clinical Reviews, Mayo Civic Aud., Rochester, Minn. Credit of 26 hours by The American Academy of General Practice and the College of Family Physicians of Canada. Info: Postgraduate Courses, Mayo Clinic–Mayo Foundation, Rochester, Minn. 55901 (repeat of Nov. 1–3 postgraduate courses).

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

Dec. 4–9: Annual Meeting, American Academy of Dermatology, Palmer House, Chicago, Ill.

1971 OTHERS

Oct. 6–7: The Cleveland Clinic Educational Foundation Postgraduate Continuation Course: *Psychiatric Aspects of Medical Practice for the General Physician.* Accredited by the American Medical Association. Info: The Cleveland Clinic Educational Foundation, 2020 E. 93rd St., Cleveland, Ohio 44106.

Oct. 8–9: Department of Otolaryngology, University of Miami School of Medicine, *Postgraduate Course in Otolaryngology,* Miami, Fla., Sheraton Four Ambassador Hotel. Info: F. W. Pullen, II, MD, Neuro-Otologic Laboratory, School of Medicine, P. O. Box 875, Biscayne Annex, Miami, Fla. 33152.

Oct. 11–13: Obstetrics and Gynecology Postgraduate Medical Education, Denver, Colo. Info: The Office of Postgraduate Medical Education, University of Colorado School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Oct. 18–22: 57th Annual Clinical Congress of the American College of Surgeons, Atlantic City, N.J. Info. Sara Barr Cohen, Director of Publicity, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611. Phone: 312/664–4050.

Oct. 20–22: 18th Western Cardiac Conference, University of Colorado Medical Center, Denison Auditorium, Denver. Info: Colorado Heart Assn., 1375 Delaware St., Denver, Colo. 80204.

Oct. 21–23: *Diabetes—An International Review—The 50th Anniversary of Insulin,* American College of Physicians, Indiana University School of Medicine, Myers Auditorium, Indianapolis, Ind. Credit of 17¾ hours allowed toward AMA "Physician's Recognition Award." Info: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Oct. 23: American Gastroenterological Association Regional Postgraduate Day at three locations: Pittsburgh, Pa., San Antonio, Tex., and Portland, Ore. Info: Mrs. Francis T. Chalmers, AGA Postgraduate Courses, Box 190, McLean, Va. 22101.

Nov. 1–5: *Respiratory Pathophysiology,* American College of Physicians, McGill University, Faculty of Medicine and Royal Victoria Hospital, Montreal, Quebec, Canada. Credit of 33 hours toward AMA "Physician's Recognition Award." Info: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Nov. 3–5: *Current Concepts of Clinical Infectious Diseases,* American College of Physicians, University of Virginia School of Medicine, Charlottesville, Va. Credit of 19 hours toward AMA "Physician's Recognition Award." Info: Registrar, Postgraduate Courses, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

Nov. 8–12: Course in *Occupational Health for Nurses,* Department of Environmental Medicine of New York University School of Medicine in cooperation with American Association of Industrial Nurses. Tuition: $175. Course No. 484. Applications to: Office of Recorder, N. Y. U. Post-Grad. Medical School, 550 First Avenue, New York, N. Y. 10016.

Nov. 9–10: Annual Scientific Meeting, Council on Arteriosclerosis of the American Heart Association, Anaheim, Calif.

continued on page 9

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Orally active androgen about 5 times as potent in anabolic and androgenic activity as methyltestosterone. Halotestin (fluoxymesterone) induces significant retention of calcium and potassium, but retention of sodium not marked. Doses below 20 mg. daily have little effect in producing creatinuria.
Indications *Male:* Replacement therapy in testicular hormone deficiency states. Prevents atrophy of the accessory male sex organs following castration for as long as therapy is continued. Impotence and male climacteric symptoms when due to androgen deficiency. Primary eunuchoidism and eunuchism. Delayed puberty when established as not a simple familial trait. Indicated for those symptoms of panhypopituitarism related to hypogonadism, however, appropriate adrenal cortical and thyroid hormone replacement therapy remain of primary importance. *Female:* Palliation of androgen-responsive, advanced, inoperable breast cancer in women between 1 and 5 years postmenopausal or women in whom castration has shown the tumor to be hormone dependent. Prevention of postpartum breast manifestations of pain and engorgement; there is no satisfactory evidence that this drug prevents or suppresses lactation per se. In osteoporosis androgens may be of adjunctive value to adequate considerations of diet, calcium balance, physiotherapy and general health promoting measures. *Males and Females:* In the treatment of protein depletion states which occur in geriatric patients, in debilitation states, in chronic corticoid therapy, resistant fractures; cryptorchidism; creating a positive nitrogen balance, tissue repair and other anabolic effects. Androgenic steroids may produce a response in aplastic anemias, myelofibrosis, myelosclerosis, agnogenic myeloid metaplasia and hypoplastic anemias due to malignancy or myelotoxic drugs. Androgens are not of value in other anemias.
Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
Adverse reactions Nausea, dyspepsia, menstrual irregularities, hepatic dysfunction, priapism, edema, precocious sexual development, and premature epiphyseal closure in young patients have been reported. *Male*—Prolonged administration or excessive dose may cause inhibition of testicular function with oligospermia and decreased ejaculation volume. *Female*—Large doses or prolonged administration may produce masculinization with signs such as hirsutism, deepening of the voice, enlargement of the clitoris, acne, and sometimes, increased libido.
Supplied *Tablets: 2 mg.*, scored—bottles of 100./*5 mg.*, scored—bottles of 50./*10 mg.*, scored—bottles of 50.
For additional product information, see your Upjohn representative or consult the package circular.

Upjohn The Upjohn Company, Kalamazoo, Michigan

JA68-7627-R MED 8-5-5 (LQX)

Nov. 10–13: Fifth Annual Postgraduate Conference on "Today's Hospital Problems—An Interdisciplinary Approach," Mound Park Hospital Foundation and the College of Medicine University of South Florida, Tides Hotel and Bath Club, Redington Beach, Fla.

Nov. 11–14: 44th Annual Scientific Sessions, American Heart Association, Convention Center, Anaheim, Calif.

Nov. 15–19: Postgraduate Medical Assembly, Interstate Postgraduate Medical Association of North America, Roosevelt Hotel, New Orleans, La. (Info: Mr. Roy T. Ragatz, Exec. Dir., IPMA, P. O. Box 5445, Madison, Wis. 53705)

Nov. 17–19: Annual Conference, National Society for the Prevention of Blindness, Inc., The Roosevelt Hotel, New York City. (Papers, panel discussion and seminars on the latest developments in detecting and combating potentially blinding eye disease, community-action eye health programs, and programs for industrial and school safety.)

1971 AMA

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Feb. 18–19: Annual Meeting, Wisconsin Otolaryngological Society, SMS Building, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Feb. 28–Mar. 3: Winter meeting, American Society of Contemporary Ophthalmology, Diplomat Hotel, Hollywood, Fla. Info: John G. Bellows, MD, Secretary, 30 North Michigan Ave., Chicago, Ill. 60602; tel. 312/236–4673.

April 21: Symposium on Infectious Diseases, American Academy of General Practice, Battenfeld Auditorium, Kansas City, Kan.

Apr. 23–29: Ninth Interamerican Congress of Cardiology, San Francisco, Calif.

Sept. 25–28: Annual scientific assembly, American Academy of General Practice, New York Coliseum, New York, N.Y.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Biltmore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New York N.Y. 10017.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

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1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1974 INTERNATIONAL

Oct. 20–26: XIth International Cancer Congress, Florence, Italy.

For listing of other meetings see the **Journal of the American Medical Association.**

Academy of Pediatrics—Chicago

The American Academy of Pediatrics will hold its 40th annual meeting at the Palmer House Hotel, Chicago, Ill., Oct. 16–21. The meeting will feature a versatile program of scientific presentations, seminars, round tables and symposiums including:

- Seven symposiums during the general sessions on teen-age pregnancy, behavior modification by drugs, divorce: its effects on children, immunizations-progress and problems, environmental hazards, mists, aerosals and oxygen, and exciting new developments in pediatrics.

- Approximately 133 papers on all facets of pediatrics to be presented during meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Community Pediatrics, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, and Surgery plus the Committee on Urology.

- Seventeen round tables covering such subjects as family therapy, seizures, allergy, failure to thrive, cardiology, visual diagnosis: neurology, and renal disease.

- Eighteen seminars covering such areas of pediatrics as cardiology for pediatricians, newborn and premature, allergy, antibiotics immunology, neurology, psychiatry, pediatric orthopedics, endocrinology, dermatology, fluids and electrolytes and renal disorders.

- Several special sessions including a symposium on children's television programming, plus meetings of the American Association of Poison Control Centers, and the AAP Council on Pediatrics Practice.

- Twelve motion picture films—each dealing with a vital aspect of pediatrics—to be shown on a regularly scheduled basis during the annual meeting.

Further info: Dept. of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

American Gastroenterological Association

The American Gastroenterological Association Regional Postgraduate Day will be held on Oct. 23 simultaneously in Pittsburgh, Pa., San Antonio, Tex., and Portland, Ore.

Postgastrectomy problems, with particular attention given to postoperative diarrhea, will occupy the morning and jaundice after colectomy, the afternoon.

This course is approved for six hours of prescribed credit by the AAGP.

The tuition fee is $50.00 ($15.00 for those in training status) with lunch included in the fee. No refunds will be made after Oct. 16, and $5.00 of the fee is nonrefundable. Further information is available from: Mrs. Frances T. Chalmers, AGA Postgraduate Courses, Box 190, McLean, Va. 22101.

Today's Hospital Problems—Florida

The Mound Park Hospital Foundation with the joint sponsorship of the College of Medicine University of South Florida will conduct the Fifth Annual Postgraduate Conference on "Today's Hospital Problems—An Interdisciplinary Approach," November 10–13 inclusive.

This postgraduate conference will be completely comprehensive and specifically designed for physicians who hold hospital staff leadership positions, hospital administrators, hospital trustees, and such allied personnel selected by hospital administration and division chiefs. Present day and newer concepts of patient care and hospital management will be stressed.

The program is acceptable for 20 accredited hours by the American Academy of General Practice for those who desire such credit. Fee: $110. It will be held at the Tides Hotel and Bath Club, Redington Beach.

Further info: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Fla. 33701.

College of Surgeons—Atlantic City

The world's largest meeting of surgeons will be held in Atlantic City, October 18–22, with the opening of the 57th annual Clinical Congress of the American College of Surgeons.

The Forum on Fundamental Surgical Problems, which is concerned exclusively with original surgical research and investigation by young surgical investigators, covers 263 research-in-progress reports alone.

Other program features will include:

—Seventeen postgraduate courses given for younger surgeons by widely experienced teachers.

—More than 45 panel discussions and symposia on current problems in general surgery and surgical specialties by experts in the field.

—More than 90 motion picture films and cine clinics, demonstrating noteworthy surgery in the United States, Canada and Mexico.

—A review of "What's New" in surgery.

—Closed-circuit telecasts of actual operations from the Thomas Jefferson University Hospital, Philadelphia.

—Approximately 450 scientific and industrial exhibits.

—Special sessions dealing with cancer, trauma, and undergraduate surgical education.

—A general session on professional liability.

—A general session also on The Surgical Education and Self-Assessment Program of the College which was designed to help Fellows and other qualified physicians evaluate the extent of their basic and clinical knowledge in surgery.

General sessions will open the convention program at 9:30 a.m., Monday, October 18.

The Dennis and Shelburne hotels will serve as convention headquarters.

For further information contact Sara Barr Cohen, Director of Publicity, American College of Surgeons, 55 East Erie Street, Chicago, Ill. 60611. Phone: (312) 664–4050.

Dermatologists Scientific Meeting—Chicago

The American Academy of Dermatology (AAD) will hold its 30th Annual Meeting at the Palmer House, Chicago, Ill., Dec. 4–9.

The Academy plans to have two days of in-depth postgraduate courses on Saturday and Sunday, Dec. 4–5, followed by four days of general scientific sessions, symposia, seminars-in-depth and small group discussions.

Among major symposia will be those covering such clinical problems in skin disease as dermatologic genetics, cutaneous tumors, pediatric skin diseases, skin allergy, psoriasis, acne, venereal diseases and new medications and therapeutic techniques.

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Introducing K-LYTE®/CL

Each dose in solution supplies 25 mEq. potassium chloride

potassium supplement with chloride

The good-tasting way to treat hypokalemias induced by thiazide diuretics and other drugs...

Here, at last, is a potassium chloride supplement that just doesn't taste like one! The mixed fruit flavor of new K-Lyte/Cl is truly refreshing. Now, K-Lyte/Cl offers your patients all of the therapeutic advantages you expect from a potassium chloride supplement. And you can be sure that your patients will take the K-Lyte/Cl you prescribe—all in good taste.

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When extra chloride is not desired, original effervescent K-Lyte is unsurpassed in flavor, effective and safe in short- or long-term potassium supplementation. There is little chance of taste fatigue from K-Lyte with two delicious, effervescent flavors to alternate...fresh-tasting orange and sparkling lime.

K-Lyte® Each effervescent tablet in solution supplies 25 mEq. potassium as bicarbonate and citrate

K-Lyte®/Cl Each dose of powder in solution supplies 25 mEq. potassium chloride

Each tablet or dose must be completely dissolved before taking.
Indications: K-Lyte and K-Lyte/Cl are oral potassium supplements for therapy or prophylaxis of potassium deficiency. Particularly useful when thiazide diuretics or corticosteroids cause excessive excretory potassium losses. **Contraindications:** Impaired renal function with oliguria or azotemia; Addison's disease; hyperkalemia from any cause. **Warnings and Precautions:** Since the amount of potassium deficiency may be difficult to determine accurately, supplements should be administered with caution, and dosages adjusted to the requirements of the individual patient. Potassium intoxication rarely occurs in patients with normal kidney function. Symptoms of potassium intoxication are variable. They include listlessness, mental confusion, and tingling of the extremities. Frequent checks of the clinical status of the patient, ECG, and serum potassium level are desirable. In established hypokalemia, attention should also be directed toward other potential electrolyte disturbances. Potassium supplements should be given cautiously to digitalized patients. To minimize the possibility of gastrointestinal irritation associated with the oral ingestion of concentrated potassium salt preparations, patients should be carefully directed to dissolve each dose completely in the stated amount of water. K-Lyte/Cl contains 4.9 grams (20 calories) of sucrose per dose which should be considered for patients with restriction of caloric intake. **Adverse Reactions:** Nausea, vomiting, diarrhea, and abdominal discomfort may occur with the use of potassium salts. **Dosage and Administration:** Adults: 1 tablet or dose *completely dissolved*, 2 to 4 times daily, depending upon the requirements of the patient: K-Lyte: 1 tablet (25 mEq. potassium) in *3 to 4 ounces of cold or ice water;* K-Lyte/Cl: 1 dose (25 mEq. potassium chloride) in *6 ounces of cold or ice water.* The normal adult daily requirement is approximately 50 mEq. of elemental potassium. NOTE: *It is suggested that these products be taken with meals and sipped slowly over a 5-10 minute period.* **How Supplied:** K-Lyte: Effervescent tablets—boxes of 30 and 250 (orange or lime flavors). K-Lyte/Cl: Powder, cans of 30 measured doses with scoop (fruit-punch flavor). Ⓡ

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Mead Johnson
LABORATORIES

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Special seminars-in-depth will be held on photosensitivity, problems of negro skin, contact dermatitis, connective tissue disorders, occupational dermatoses, immunology and clinical and basic aspects of blood lipids.

Info: Frederick F. J. Kingery, MD, Secretary–Treasurer, AAD, 2250 Northwest Flanders St., Portland, Ore. 97210.

British National Health Service Topic

J. Enoch Powell, chief of the British National Health Service from 1960 to 1963, will be in the United States on October 8 to address the annual meeting of the Association of American Physicians and Surgeons. The meeting will be in Clayton, Mo., a suburb of St. Louis.

The ex-Minister of Health in Great Britain is regarded as the world's leading authority on politically controlled medicine. After trying for three years to make the British national health plan work, he now admits it is an inherent failure. He will explain the nature of that failure during the 3-day AAPS meeting in October. In addition, he will examine the whole network of connections between medicine and politics.

Powell has remained close to British politics since leaving his position as Minister of Health, and currently is a member of Parliament, representing an industrial district centering on Birmingham, England.

Frontiers of Medicine 1971—Florida

The 1971 meeting of Frontiers of Medicine has been cancelled because convention facilities sufficient for the Lakeland Graduate Medical Assembly purposes are not available at this time, the Assembly's executive director, Mrs. Gail Geary Moore, has announced.

Perinatal Medicine Seminar—Madison

A Perinatal Medicine Seminar will be the central feature of the District VI meeting of the American College of Obstetricians and Gynecologists in Madison on September 30—October 2, at the Loraine Hotel and Park Motor Inn.

For advance registration forms (nurses and physicians) write: C. Weir Horswill, MD, FACOG, General Arrangements Chairman, University Hospitals, 1300 University Ave., Madison, Wis. 53706. □

UNIVERSITY OF MINNESOTA

Office of Postgraduate Medical Education—Medical School

CONTINUING MEDICAL EDUCATION COURSES 1971–1972

1971

OCTOBER

7–9 _____Clinical Neurologic Syndromes
15–16 _____Hypertension Symposium
18–22 _____Pediatric Radiology
21 _____Minnesota Medical Alumni Program
28 _____Pediatric Neurology
29 _____Medical Audit Conference

NOVEMBER

11–13 _____Refraction—for Non-Ophthalmologists (limited enrollment)
12–14 _____Second Annual Kidney Foundation Symposium
18–20 _____Application of the Health Science Computers in the Community Hospital

DECEMBER

2–4 _____Clinic Management for Doctors
6–7 Ophthalmic Manifestations of General Disease

1972

JANUARY

13–15 _____Clinical Hypersensitivity Problems in the Upper Midwest

FEBRUARY

21–22 _____Practical Ear, Nose, Throat Program
23–24 ____Elective Clinical Program in E. N. T. (limited enrollment)

MARCH

9–11 Clinical Therapeutics: A Rational Approach to Drug Utilization
20–22 _____Cardiology

APRIL

13–15 _____Practical Urology
24–26 _____Arthritis and Rheumatic Disorders

MAY

1–2 _____Ophthalmology for Specialists
10–12 _____International Symposium on Laboratory Medicine
22–24 _____Anesthesiology
22–24 _____Surgery for Specialists

JUNE

5–7 _Interrelationships Between Immunopathology, Virology, and Membrane Structure

Therapeutic Radiology—to be announced. Additional courses may be announced during the year.

For further information concerning the above listed programs and opportunities contact:

Office of Postgraduate Medical Education
Box 193 Health Sciences Center
University of Minnesota
Minneapolis, Minnesota 55455

American College of Chest Physicians
1971–1972 Postgraduate Programs

The American College of Chest Physicians, in cosponsorship with leading medical schools and teaching hospitals, presents a continuing education program for physicians with special interest and clinical needs in the realm of circulation, respiration, and related disciplines.

The following programs are listed by course number, title, dates, and location:

1971

3—Intensive Cardiorespiratory Care: A Symposium for Nurses, Inhalation and Physical Therapists, Oct. 25, Philadelphia, Pa.

4—Mayo Clinic Conference on the Management of Respiratory Insufficiency, Nov. 18–20, Rochester, Minn.

5—Chest Trauma—Recent Advances in Emergency Management, Dec. 3–5, New York, N. Y.

1972

6—Intensive Respiratory Care for Nurses, Inhalation and Physical Therapists, Jan. 19–21, Salt Lake City, Utah.

7—Respiratory Function and Therapy, Jan. 27–29, Los Angeles, Calif.

8—Management of Cardiorespiratory Failure, Mar. 5–10, Miami, Fla.

9—Team Management of Acute Respiratory Failure, Apr. 12–14, Cleveland, Ohio.

10—Pulmonary Care in the Seventies, May 3–6, Philadelphia, Pa.

11—Coronary Heart Disease—A Guide to the Practitioner, May 12–13, Boston, Mass.

12—Acute Medicine Symposium, 1972, May 25–27, Pittsburgh, Pa.

13—Coronary Artery Disease, 1972, Sept. 21–23, New York, N. Y.

Info: ACCP, 112 East Chestnut St., Chicago, Ill. 60611.

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Health Task Force Probes State for Barriers to Care

Probing for symptoms of morbidity in health care, members of Governor Lucey's Health Planning and Policy Task Force have spent a month listening to the state's pulse at eight vital locations.

In regional public hearings, Task Force members heard consumers and providers of health care and members of government agencies air their views on the state's health problems.

Task Force chairman David Carley opened the hearings August 10 in Milwaukee by saying that the group wanted to hear state citizens' opinions. He said he hoped these would be the basis for making Wisconsin's health care system the best in the nation. He noted that Washington is watching the Task Force to see how citizens feel and what can be done to solve health care problems.

Physicians were well represented at all of the hearings which, following Milwaukee, were held in La Crosse, Green Bay, Oshkosh, Eau Claire, Spooner, Stevens Point, and Madison. Because many people in the north central part of the state felt their area was not adequately represented, a ninth session was added in Rhinelander, September 8.

Many of the statements made at the hearings had a familiar ring, especially those citing the health manpower shortage as one of the state's most pressing problems.

State Medical Society president George A. Behnke, MD, Kaukauna, stated the Society's position at the third hearing, held in Green Bay.

He said, "I would like to make it clear that we recognize that more physicians are needed to meet the needs in many areas . . . We must seek ways to attract physicians into the rural and shortage areas."

Several providers and consumers pointed out that current health problems are not new and action is vitally needed as soon as possible.

State Medical Society president-elect Robert F. Purtell, MD, Milwaukee, made a statement to the Milwaukee Task Force hearing urging state government action on "suggested remedies for the state's health problems."

In La Crosse, SMS councilor Elmer P. Rohde, MD, Galesville, said physicians can only hope the Task Force will heed the suggestions that have been made by the State Medical Society and others.

Paul E. Wainscott, MD, Menasha, said in Oshkosh, "we feel that actions speak louder than words and what we need now is action and legislative support." Dr. Wainscott is president-elect of the Wisconsin Academy of General Practice and president of the Winnebago County Medical Society.

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Wide Range of State Professionals to Team up for Work Week of Health

"Teaming Up for Better Health" is the general theme for the 1971 Wisconsin Work Week of Health October 19–22.

"Teaming up" with the State Medical Society for the week's programs will be a wide variety of people who will hear speakers on a potpourri of topics presented at four locations.

This will be the ninth annual Work Week under the sponsorship of the State Medical Society of Wisconsin and other cooperating agencies. This year it coincides with the American Medical Association's Community Health Week which is giving national publicity to the need for health education on venereal disease and drug abuse.

These two topics are to be included in the Work Week's first program, "Crisis Counseling" for teenagers, which also will include family life education. Other sessions during the week include discussions on nursing homes and special problems of the aged, and progress in voluntary health insurance. The latter will be part of a special program marking the 25th anniversary of the State Medical Society's health insurance program, Wisconsin Physicians Service (WPS–Blue Shield).

During the week, the State Medical Society also is co-sponsoring two programs with other health organizations: one with the Wisconsin Hospital Association as part of its two-day convention in Oshkosh and the other in cooperation with the Wisconsin Association on Al-

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Health Task Force

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Coordinated planning for good health services was particularly stressed in the Green Bay testimony of SMS councilor J. E. Dettmann, MD, Green Bay. At other hearings:

- SMS councilor Walton R. Manz, MD, Eau Claire, stressed the high cost of quackery and the need for public health education;
- Dale V. Moen, MD, Shell Lake, chairman of the SMS Commission on Hospital Relations and Medical Education, called for legislative passage of medical school funding and physician assistant certification;
- SMS councilor Russell F. Lewis, MD, Marshfield, suggested a plan be found to help reduce physicians' increasing load of paperwork.

Consumers, when asked their opinion on major barriers to health care, had a wide range of responses. Cost was often mentioned as an outstanding problem. The plea for coverage of chiropractic services under Medicare and similar programs was also frequently heard from chiropractic patients who "turned out in number" (as the *Wisconsin State Journal* put it after the Madison hearing).

However, the number of physicians testifying was cause for comment elsewhere. State Senator Everett V. Bidwell, Portage, stated at the La Crosse hearing that he was delighted to see so many doctors making statements. He promised to bring the physicians' attendance to the attention of the state legislature.

In Madison, the testimony of Gerald J. Derus, MD, Madison, was followed by several questions from Chairman Carley, who said the Task Force would consult further with Dr. Derus. Dr. Derus heads the SMS Commission on Scientific Medicine and is president-elect of the Dane County Medical Society.

FOUR MEMBERS OF GOV. PATRICK LUCEY'S Health Planning and Policy Task Force at the Eau Claire public hearing August 24 are shown above addressing a group of over 100 persons: Mrs. Barbara Shade, Madison; L. J. English, DDS, Arcadia, Task Force vice-chairman; Ben R. Lawton, MD, Marshfield, chairman; and Marshall Erdman, Madison. (EAU CLAIRE LEADER Photo)

In addition to physicians, health care providers who testified included a broad spectrum of nurses, social services' representatives, health planners, hospital and nursing home administrators, and insurance agents.

Task Force vice-chairman Ben R. Lawton, MD, Marshfield, ended the Eau Claire hearing by saying he had not heard enough testimony from the grass roots—the avowed aim of the hearings. This was even more the case in Oshkosh, where no consumers at all testified. Physicians attending hearings to learn consumer grievances often came away with scant information.

The Task Force now has the job of reviewing thousands of words of testimony and dozens of documents. Its first report must go to the Governor by October 1.

Nine physicians and State Medical Society Secretary are members of the 49-member Task Force.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

CES Foundation Offers Awards for Medical History Essays

The history of medicine in Wisconsin could prove a lucrative topic for an interested student this semester.

The State Medical Society's Charitable, Educational and Scientific Foundation (CESF) is offering three scholarship awards for the best research papers dealing with the history of medicine in Wisconsin during the period 1800 to 1900.

The awards are for $250, $150, and $100.

Examples of possible topics are history of Indian medicine, frontier doctors, history of Wisconsin hospitals, and medical school history before the turn of the century. Papers should be typewritten and a maximum of 5,000 words with appropriate bibliography.

Those who plan to submit a paper should notify CESF of their entry before October 15. Papers must then be completed and submitted before Jan. 1, 1972, for judging by a committee appointed by CESF.

MCW Sets Symposium on Medical Education

A Symposium on Medical Education will be presented by The Medical College of Wisconsin, October 2 and 3, at the Pioneer Inn in Oshkosh.

Having as its theme, "Directions for Change in the '70's," the symposium is the first in a series of yearly meetings on medical education for the Medical College's faculty and others who have an expressed interest in exploring the projected needs, objectives, and functions of the College during the next decade.

Guest speakers will be coming from California, New York, Illinois, Texas, North Carolina, and Wisconsin.

Keynote speaker for the Saturday evening dinner will be David Carley of Madison, chairman of the Governor's Health Planning and Policy Task Force.

Advance registration is required. Details may be obtained by contacting the Public Information Office, MCW, Room 125, 561 N. 15th St., Milwaukee, Wis. 53233.

County Societies Study Unique Insurance Plan

Several Wisconsin county medical societies are studying an experimental health maintenance program proposed by Wisconsin Physicians Service (WPS), the Blue Shield plan of the State Medical Society of Wisconsin.

The unique new health insurance plan provides outpatient benefits including office calls, consultation visits, and diagnostic services. It is designed to encourage the use of less costly settings as an alternative to inpatient hospital confinement. It encourages patients to seek care that will result in early detection and prevention of illness.

The plan is a way in which both the county medical society and WPS can gain knowledge and experience with prepaid group practice while maintaining free choice of physician and the physician-patient relationship. Thus, the public and physicians can determine on an individual basis whether they wish to participate in the experiment. The WPS program fits into the existing pattern of multiple types of physician practice and function with and through the ongoing physician referral system.

The method of payment for services is flexible. It depends on the number of specialties and physical facilities used.

A monthly "health maintenance fee" is used for basic services and is expected to cover most high frequency, low cost services. This would markedly reduce time and effort spent in recording, reporting, and payment procedures. Infrequent, high cost service could be paid for by a combination of the health maintenance fee and a fee for service.

Savings made possible through less cumbersome administration along with the additional advantages of the plan's peer review system could be reflected in broader benefits and help hold the line on premium cost.

Physicians who participate in the program are assured of receiving the monthly health maintenance fee and predetermined fee-for-service payments for a mutually agreed upon period of time. The health maintenance fee will be reviewed annually to establish the proper level for the following year.

The initial enrollees in the plan will be those under age 65 from interested employer groups.

When joining the plan, a member names the physician or medical group who will be his primary provider of care. (This can be changed with a 30-day notice to WPS.) Each primary provider will be sent the names of those eligible for care under the plan by the first of each month. This list will be accompanied by the advance payment of that month's health maintenance fee.

When primary physicians and medical groups render services to plan members, they report them to WPS on a simplified master monthly reporting form. This includes the name of the patient, his patient number, and a coded indication of the type of service rendered.

Fee-for-service claims also will be made on a master monthly reporting form. This one report will provide information for all services provided patients during a one-month period, again lessening physician administrative expenses.

The WPS health maintenance plan is designed to enlist participation by individual physicians, partnerships, and groups. With an entire county medical society involved, a collective determination can be made on its advantages or disadvantages.

Wisconsin Professional Group to Meet Oct. 23

Representatives of nine professions in Wisconsin will meet October 23 in Oshkosh to discuss "education, ecology, and economics."

The Annual Congress of the Wisconsin Association of Professions (WAP), will meet for an all-day session at the Pioneer Inn.

Program chairman is Nels A. Hill, MD, of Madison, vice-president of WAP.

WAP is a five-year-old organization of architects, lawyers, physicians, educators, pharmacists, engineers, dentists, veterinarians, and certified public accountants.

The Oshkosh Congress is open to all Wisconsin professionals in these areas who are eligible for membership, whether or not they belong to WAP.

Pre-registration is encouraged by a reduced fee of $7.50; $10.00 for those who register on the day of the Congress. Interested persons may contact WAP, Box 1109, Madison, Wis. 53701, for assistance in advance registration.

WAGE–PRICE FREEZE INQUIRIES
Tel: 1–800–452–9100
(toll free)

Wage–Price Freeze Affects MDs, too!

All members of the State Medical Society of Wisconsin were advised by letter on September 1 of the principal points of interest to physicians with regard to the President's Wage–Price Freeze Order.

The following determinations have been made by the Office of Emergency Preparedness, or the Cost of Living Council, the two agencies that have been charged by the President to administer the Order.

1. *In the case of a self-employed physician,* meaning one who practices alone or has a partner in a group of two or more physicians, the Freeze Order is applicable to his professional fees. This means that no increase in fees for particular professional services is permitted during the freeze beginning Aug. 15, 1971.
2. *In the case of an employed physician,* no cost of living, merit or longevity increases are permitted during the freeze period, nor is a negotiated increase which had not taken effect on Aug. 15, 1971. This is also true of all *nonphysician employees* of a physician or group of physicians.
3. *In the case of an employed physician,* a promotion and higher pay is permitted if it is shown that:
   a. the promotion is genuine;
   b. the position was established prior to August 15, 1971; and
   c. the responsibilities of the new position are greater.

   This exception is also applicable to *nonphysician employees* of a physician or group of physicians.

As additional official information of interest to physicians is announced, the Society will inform its members as promptly as it can be verified. In the meantime, physicians may call (toll free) 1–800–452–9100 for further information on specific questions.

SMS Hot Line

KENNEDY-GRIFFITHS BILL supporters have selected Wisconsin's 8th Congressional District as one of 10 key districts in the country where they will work to achieve its passage. In Marinette, labor union representatives, some health professionals, and politicians met August 3 to form a regional committee known as Northeastern Wisconsin Citizens Committee for Comprehensive Health Care. Co-chairmen are two UAW representatives. Committee members will ask to appear before the House Ways and Means Committee, see Rep. John Byrnes, and arrange a one-day public educational workshop on the bill.

HAROLD J. KIEF, MD, Fond du Lac's city health officer and a past president of the State Medical Society, has been reelected vice-chairman of the State Health and Social Services Board.

PRESIDENT NIXON'S AMA ADDRESS in Atlantic City has been edited to 25 minutes and is available on 16 mm sound and color film. Current distribution plans call for one print for each state association and one or two back-up prints in each field office. Bookings are being taken now for showings of "A Presidential Challenge."

BNDD REGISTRATION has been extended from July 29 to October 1 to allow the Bureau of Narcotics and Dangerous Drugs more time to process a backlog of applications. Inquiries should be directed to: BNDD Regional Office, Engineering Bldg., Suite 1700, 205 W. Wacker Drive, Chicago, Ill. 60606.

KENNETH JAMRON of Milwaukee, vice-president of the Hospital Council of Greater Milwaukee and a fellow in the American College of Hospital Administrators, has been appointed to the Board of Nursing by Governor Lucey. Governor Lucey also reappointed Sister Mary Touchett, CSA, RN of Fond du Lac to the Nursing Board.

WORK WEEK OF HEALTH

continued from page 25

coholism's day-long program in Wausau on alcoholism and drug abuse in industry.

A capsule look at what will be happening during the Work Week is as follows:

Tuesday, Oct. 19—CRISIS COUNSELING for teenagers, to be presented at the State Medical Society headquarters in Madison. Special guests for this session on drug abuse, venereal disease, and family life education will include school psychiatrists, psychologists, social workers, guidance counselors, and nurses as well as public health personnel.

Wednesday, Oct. 20—SPECIAL PROBLEMS OF THE NURSING HOME PATIENT, at Milwaukee Area Technical College, Milwaukee campus. The day-long program will feature talks by experts including an otolaryngologist, ophthalmologist, dentist, dermatologist, gynecologist, psychiatrist, and a physical therapist. Craig Larson, MD, Milwaukee, chairman of the SMS Division on Aging, will moderate. Nursing home and public health personnel will be special guests.

Thursday, Oct. 21—WPS-25; PROGRESS IN VOLUNTARY HEALTH INSURANCE, at SMS headquarters in Madison. Representatives of national health insurance groups, including the Health Insurance Council, the Health Insurance Association, and the Blue Cross and Blue Shield Plans have been invited to discuss where health insurance is today, where it has been, and where it is going.

Friday, Oct. 22—Programs held in two locations. ALCOHOLISM AND DRUG ABUSE IN INDUSTRY, at Wausau Midway Motor Lodge, co-sponsored with the Wisconsin Association on Alcoholism; and WHAT'S OUR LEGAL RESPONSIBILITY TO OUR PATIENTS, at Oshkosh Pioneer Inn, co-sponsored with the Wisconsin Hospital Association.

TEAMING UP FOR BETTER HEALTH

The Wausau program will be of special interest to personnel directors and others in Wisconsin industrial management, occupational health nurses and other occupational health personnel, as well as physicians particularly concerned with industrial medicine and treatment of alcoholism and drug abuse. The Hospital Association convention is attended by a wide range of hospital personnel, including administrators, physicians, nurses, and members of allied health fields.

Full details will be mailed all physicians in early October.

New Job Safety Act—What MDs Should Know

All physicians, both in their treatment of employment-related injuries and as employers themselves, should be aware of new rules and forms specified by the William–Steiger Occupational Safety and Health Act of 1970.

The new law was discussed in depth at a July 30 Conference on Occupational Health at State Medical Society headquarters in Madison. The conference was sponsored jointly by the SMS Committee on Occupational Health and the American Academy of Occupational Medicine, under the chairmanship of Carl Zenz, MD of West Allis.

The Williams–Steiger Act affects all businesses involved in interstate commerce, except the mining and railroad industries which are covered by other laws. Because the act is so broadly drawn, virtually every working man and woman in the country is potentially covered by it.

Record-keeping requirements specified by the law went into effect July 1. A booklet explaining how records must be kept was sent to employers by the U. S. Department of Labor in June.

The law says that a report to the Labor Department must be made on any occupational accident or illness which involves any lost time, loss of consciousness, job change (either temporary or permanent), or any medical treatment requiring a visit to a physician. The Labor Department will keep a running log for each industrial or commercial plant to determine whether any hazardous situations exist.

Any employee who believes there is a hazard where he works may ask the Labor Department to inspect his job site. The Labor Department will also conduct a steady round of unannounced investigations. These started August 27 with 300 federal inspectors checking for danger and writing up the violators.

Five large industries with high injury records have been selected by the Labor Department as the first to be inspected under the Act. These target industries are longshoring, roofing and sheet metal, metal and metal products, lumber and wood products, and mobile homes and miscellaneous transportation equipment.

Louis Olsman, MD of Kenosha, chairman of the SMS Committee on Occupational Health and a participant in the Conference, stated that the law if strictly interpreted can apply to all doctors' offices. Physicians who should be particularly alert to the law are those in clinics or large group practices and those who use x-ray machines, radioactive materials, and oxygen or anesthetic gases in their offices. Safety regulations under the law apply particularly to this type of equipment.

If a clinic or a group practice receives information from the Federal Occupational Safety and Health Administration, this is reason to assume that they are required to keep records under the law. This would concern such things as injuries to employees, exposure to radiation and to certain anesthetic gases. In addition, periodic reports to the federal government would be required. Such physicians should also take steps to obtain copies of the regulations pertaining to radiation exposure and exposure to anesthetic gases.

Physicians, clinics, or group practices not sent forms can request information about the new law from the office of Occupational Safety and Health, Room 848, 219 S. Dearborn St., Chicago, Ill.

Physician treatment of injuries also takes on new implications under the law. An MD's decision that an injury or illness is job-related can have far-reaching financial and administrative implications to the employer. A plant can be shut down if it is found to have conditions causing death or immediate serious harm.

Many industrial enterprises, particularly those too small to have a medical director, will have to seek medical advice about industrial hazards.

The July 30 Occupational Health Conference in Madison suggested that each county medical society form an occupational health committee which would be able to provide detailed advice to local industry.

Conference discussants included medical directors of many of the major industrial, transportation, and communications corporations in the country. Among those attending was Jack Schulte, MD, president of the American Academy of Occupational Medicine and professor of occupational medicine at Ohio State University.

Others came from North Carolina, Ohio, Delaware, Connecticut, Illinois, Colorado, Michigan, and Wisconsin.

Wisconsin physicians present, in addition to Doctors Zenz and Olsman, were Simon Weisfeldt and Victor J. Wong of Milwaukee, David Miller of Kenosha, T. J. Nereim, Paul Ebling, and George H. Handy of Madison.

CMCP Reelects Officers

Five physicians have been reelected as officers of the State Medical Society's Commission on Medical Care Plans. The Commission directs WPS–Blue Shield.

The officers are MDs Robert Krohn, Black River Falls, vice-chairman; John T. Sprague, Madison, treasurer; R. A. Sievert, Madison, assistant treasurer; and D. N. Goldstein, Kenosha, and W. T. Casper, Milwaukee, delegates to the National Association of Blue Shield Plans.

Chairman of the Commission is E. M. Dessloch, MD of Prairie du Chien.

Seminars Slated On Safety Act

All Wisconsin physicians are encouraged to attend a one-day participation seminar on the new Federal Occupational Safety and Health Act in Wisconsin. The Wisconsin Council of Safety (WCS) is sponsoring the seminar in three different state locations.

Representatives of WCS, federal and state government, industry, and legal counsel will participate in the program. Topics include record keeping under the new Act, appeal procedures, and a progress report.

Locations and dates are: Green Bay, Wednesday, Sept. 22; Milwaukee, Wednesday, Sept. 29; and La Crosse, Monday, Oct. 4. Advance registration is $20 for members of WCS and co-sponsoring organizations and $30 for nonmembers. Registration at the door is $5 additional.

Co-sponsors include six state manufacturers' and employers' associations and state and federal governments in cooperation with local safety councils.

Doctor McCarey Memorial Dedicated at Museum

A medical museum which he helped establish was the site of July 17 ceremonies honoring the late Arthur J. McCarey, MD, of Green Bay.

A 10-foot-long reproduction of the route of the "Old Military Road" which went from Green Bay to Prairie du Chien was dedicated to his memory and placed on permanent display at the Museum of Medical Progress in Prairie du Chien. Dedication ceremonies were attended by 60 of his friends, colleagues, and family, along with mayors of both Green Bay and Prairie du Chien.

The map was made from copies of the original road survey map and engraved to scale in redwood.

Dr. McCarey died at the age of 82 on Jan. 9, 1971. The 1954 State Medical Society president had a long interest in state medical history. He was instrumental in establishing the Museum of Medical Progress, now owned and operated by the State Medical Society's Charitable, Educational and Scientific Foundation. His family directed that memorials to his name be used by the Foundation in this way.

Participants in the ceremonies were W. D. Stovall, MD, Madison, president emeritus of the Foundation; E. J. Nordby, MD, Madison, chairman of the State Medical Society's Council; E. M. Dessloch, MD, Prairie du Chien, chairman of the Commission on Medical Care Plans; and Dr. J. E. Dettmann, Green Bay, a councilor from the State Medical Society's sixth district; Mayor Ambrose Lacke, Prairie du Chien; and Mayor Donald A. Tilleman, Green Bay.

SPECIAL GUESTS AND PARTICIPANTS IN THE July 17 dedication of the "Old Military Road" map replica, honoring the late Arthur J. McCarey, MD of Green Bay, standing in front of the 10-foot-long wooden map (left to right) are: E. M. Dessloch, MD, Prairie du Chien; Mrs. John Stathas, Green Bay; W. D. Stovall, MD, Madison; Mrs. John Faas, McHenry, Ill.; and J. E. Dettmann, MD, Green Bay. The women are daughters of Doctor McCarey. A third daughter, Mrs. George Fowler of Boca Raton, Fla., was unable to attend.

AMA to Hold Nutritional Seminars in State in October and November

The American Medical Association's Council on Foods and Nutrition will be sponsoring a nutritional program of seminars and lectures on 12 Wisconsin colleges and university campuses this fall.

The State Medical Society of Wisconsin is co-sponsoring the program which is aimed at informing students and faculty of recent nutritional developments and to stimulate interest in the medical sciences.

The program and schedule follow:

Edgar S. Gordon, MD, professor of medicine at the University of Wisconsin Medical Center, Madison, will speak on "Diabetes and Heart Attacks—Two Interrelated Diseases" at the following schools:

Wisconsin State University–Oshkosh
Wednesday, October 6—7:00 pm
Halsey Science Center—Room 109

St. Norbert College–West de Pere
Thursday, October 7—2:30 pm

Wisconsin State University–Stevens Point
Tuesday, October 12—7:30 pm

Beloit College–Beloit
Friday, October 15—2:00 pm
Morgan Room of Mayer Hall

Wisconsin State University–Whitewater
Tuesday, November 30—8:00 pm

Charles C. Lobeck, MD, professor and chairman, Department of Pediatrics, University of Wisconsin Medical Center, Madison, will speak on "Why Are We Concerned About Our Children" at the following schools:

Wisconsin State University–Superior
Wednesday, October 6

Wisconsin State University–Eau Claire
Monday, November 15

Wisconsin State University–River Falls
Tuesday, November 16—2:00 pm

George L. Baker, MD, assistant dean of medical student affairs, University of Iowa College of Medicine, Iowa City, will speak on "Don't Interfere with the Lifeline" at the following school:

Wisconsin State University–Platteville
Thursday, October 14—4:00 pm

Ladislav P. Novak, PhD, director, Laboratories of Body Composition and Whole Body Counting, Mayo Clinic, Rochester, Minn., will speak on "A Body—What Shapes It" at the following school:

Wisconsin State University–La Crosse
Monday, November 15

The AMA's Council has been working with the county medical society officers of those counties where the schools are located and with the medical directors of the schools in setting up the program.

Also assisting the AMA's Council is Peter A. Gardetto, MD of Racine who is the State Medical Society's representative member of the Wisconsin Nutrition Council.

A similar nutritional program was held in Wisconsin during the 1964–65 academic year.

PRESIDENT'S PAGE

Public Enemy No. 1

At the American Medical Association meeting in Atlantic City, June 1971, President Nixon called drug abuse "America's public enemy number one" and called upon the medical profession to take a leadership role in solving the problem.

In response to the President's request, I am asking all members of our State Medical Society to take part in an extensive educational campaign directed at halting the rise in drug abuse. We as physicians must take leadership in convincing the public that people cannot find happiness and satisfaction or expect to solve their social and emotional problems with a handful of pills or a bottle.

I'm asking all physicians to stop prescribing amphetamines and methamphetamines except in those specific cases of legitimate medical need.

Physicians are urged to carefully review their precription practices and to exercise extreme caution in recommending any drug with abuse potential.

All physicians are being encouraged to turn educator and take a few minutes with each patient to explain the dangers, if any, of prescriptions that have any chance of abuse possibility.

I'm asking each County Medical Society to appoint a committee to cooperate with other drug-prescribing professions and the pharmacists in starting an educational program for both public and medical groups. Let us emphasize the need for honest facts, not myths or sermons, on all drugs. It is going to take a great deal of education to change the public's understanding that people can't expect to solve their problems by taking a pill or crawling into a bottle.

Physicians becoming involved in this way are showing the whole community that we as a Society have a concern for the health and well-being of all citizens. Our leadership is essential because drug abuse is a medical problem. If we do not assume this leadership, the problems will grow to even greater proportions.

G. A. Behnke M.D.

G. A. Behnke, MD

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EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

Off With His Head

THE BUSY PRACTITIONER of medicine, wherever he may be throughout the State of Wisconsin, finds himself almost completely absorbed in what James Reston has called the "theatre of the problem" rather than the problem itself. His rhetoric referred to the war, where the theatre of the problem would be the map of daily hills won, casualties and picture of atrocities, and where the large problem would be the whys and wherefores of what we are doing there, and where are we going from here, et cetera.

Transposing this differentiation to our practices of medicine, we can become absorbed, even effectively, in patient care, in family responsibilities, and in hospital politics. We can become so absorbed that we may fail to attend to the larger issues of what has been called the "coming medical war." President Nixon has made some early predictions about changes to come. Senator Kennedy has made even more radical challenges and has even exploded with impatience at the conservatism of the medical profession.

Last month, in this column, I mentioned the pressures from within, that is from our forty graduating medical students at the Medical College of Wisconsin. The public press and the publishers of books are spilling forth torrents of articles and books, for the most part critical of us. As the drums begin to beat, we should heed the fate of Lavoisier, the oxygen man, whose head rolled during the French revolution, for freedom, for liberty and for equality, but more clearly because "the revolution had no need of chemists." Curiously we seem to be in about that same position. As social issues become predominant in the political arena, medicine slips consistently out of focus. Somehow the skills we know and cherish seem to matter less and less.

Chiropractic is offered the public, in Wisconsin, under the rubric of "free choice of health services." In this regard physicians are feeling now what psychiatry had had to deal with from the very first. Free choice to deal with one's emotional problems means freedom to go to social worker, friend or whosoever chooses to minister to the sick at heart. We are even "free" to take chemical soporifics from wherever they can be drawn, prescriptions, pot or proprietary, if that be our desire. Perhaps the readers of this *Journal* can help in defining what

is forming in the minds of those who would heroically, and not really inhumanly, provide health services for all.

The method behind such changes is important now, not how to treat this or that disease. We are schooled in the latter, but must now school ourselves in the former. It seems to me that the idea runs something like this. By careful cultivation of all health facilities, and by detailed study of all medical functions, each piece of human pain and dysfunction can be identified. Then specific, if not yet computerized, solutions can be proferred to each citizen.

Some of the more avant-garde suggestions visualize an aggressive program to bring health, as now being defined, into home, office, and school. This is in strict contrast to the self-demand system now. We experience self-demand from patients, and seldom bridge that gap, except for communicable diseases. This effort alone commands many life times full of medical energy. Perhaps that is why we hardly notice when part of our head is cut off. By head, of course, is meant our medical prerogative, to determine the course of health events. To cut off our head is to divide our functions so that very little remains, thus effectively reducing the physician to increasingly narrow specific treatments.

Another way to accomplish this is to evoke the economic dogma propounded by many persons, but specifically by Shaw in his "The Doctors' Dilemma": "that any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity."

A final scheme, which may or may not decapitate physicians, as we know the practice now, has to do with the hardening of institutional practices, so that everything becomes channeled, not necessarily by physicians, into bins for this or that diagnosis, and this or that treatment. More of this. Right now, like the little fellow in the picture, is our head really gone,—yet?—RH

Antibiotic Sensitivity Testing

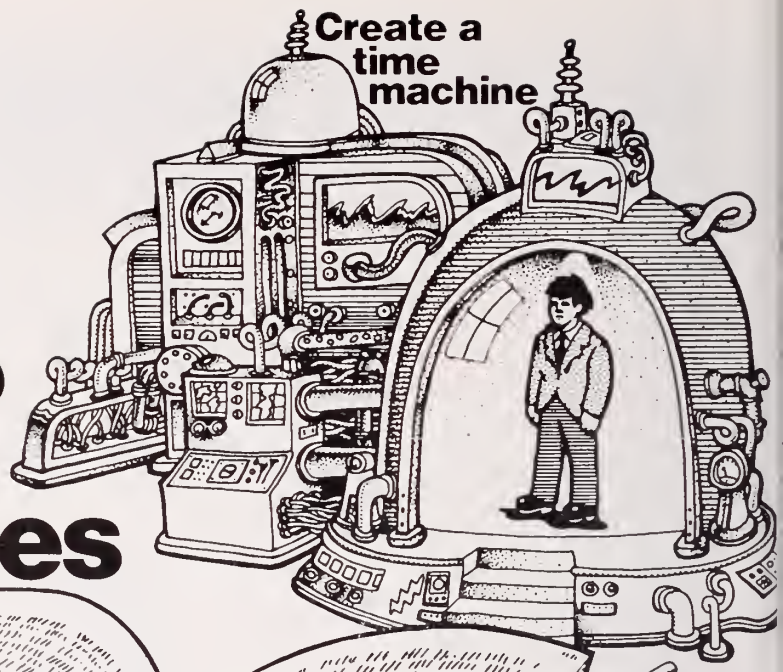
No other diagnostic laboratory procedure is performed with more incomprehension of the principles involved, or generates more confusion in those trying to interpret its results, than antibiotic sensitivity testing. Dr. Calvin M. Kunin, a nationally recognized authority in infectious diseases and Professor of Medicine at the University of Wisconsin deserves our real gratitude for his timely and lucid article on the subject of antibiotic sensitivity tests, which appears in this issue of the *Wisconsin Medical Journal.*

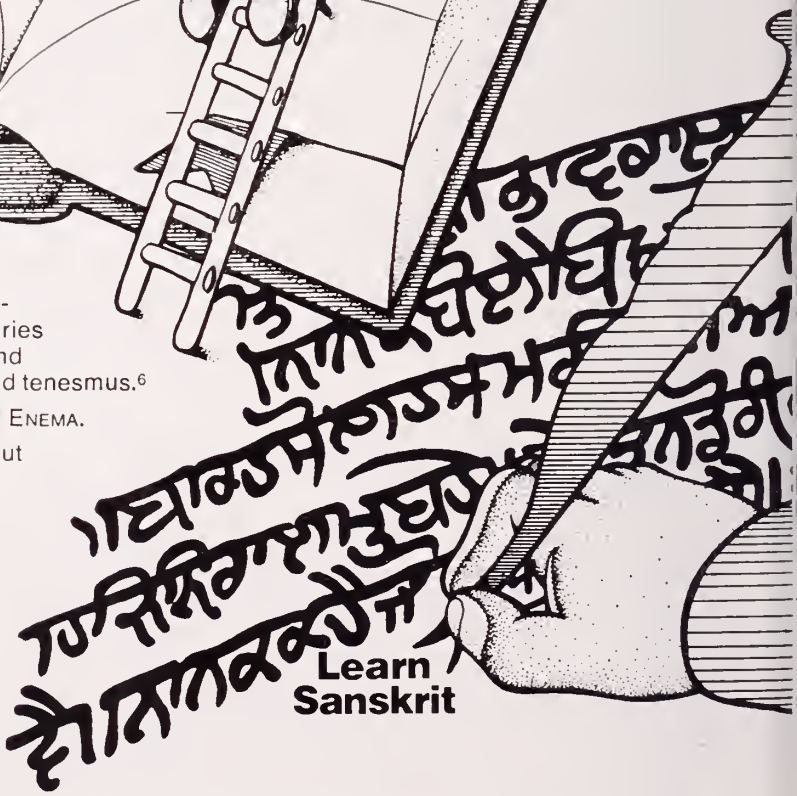
We have recently completed revision of the antibiotic sensitivity tests to be routinely employed at one of the main teaching hospitals of the Medical College of Wisconsin. We have started with the premise that the antibiogram should serve as an educational tool reflecting the most up-to-date concepts regarding antibiotic therapy. Thus, we have deleted certain antibiotics which should no longer play a role in systemic therapy; we have chosen one prototype antibiotic to represent a given family (i.e. one cephalosporin, one tetracycline, etc.)—since sensitivity results can be readily extrapolated to other antimicrobials in the group; finally we have narrowed the spectrum of antibiotics to be tested for activity against certain microorganisms (such as the Pseudomonas). The end result closely approximates Doctor Kunin's selection described in Table 1 of his article. Incidentally, we have included one additional antibiotic which does not appear in Doctor Kunin's table, namely carbenicillin, restricting its routine testing to Pseudomonas and Proteus species. We feel that our new *routine* antibiogram (and I stress the word *routine,* because in special circumstances the laboratory will honor *all* rational requests), will lessen the risk of miscalculation which could have disastrous effects on the patient.

We are fortunate in that our hospital laboratory has been for years employing the Kirby–Bauer technique of sensitivity testing, described in Doctor Kunin's article. This procedure, which has been developed jointly by a clinical microbiologist and an infectious disease clinician, takes into account not only the intrinsic sensitivity of the infectious agent to a given antibiotic (MIC), but also the serum levels of the antibiotic achieved with its usual dose, as well as the clinical experience with the use of this drug in therapy of infections caused by the organisms in question. Thus, implicit in the designation of the organism as "sensitive" or "resistant" to a given antibiotic is the expected clinical efficacy of the drug in a given infection. Unfortunately, all too many clinical laboratories in this area employ antibiotic sensitivity tests for less well standardized and relying on more arbitrary criteria of sensitivity than the Kirby–Bauer technique.

Let us take to heart Doctor Kunin's concluding admonishment that the responsibility for improving the quality of antibiotic-sensitivity tests should be shared by the diagnostic microbiologist and the interested clinician. The clinician should keep the laboratory abreast of the latest developments in the field of antibiotic therapy, should periodically review the antibiogram, and should make sure that all his requests for sensitivity testing are legitimate. The microbiologist should bring his techniques up to date, particularly in setting up the Kirby–Bauer (or related) method if he hasn't already done so, and he should resist the temptation of cluttering up the antibiogram with every "new" antibiotic, merely because he has been provided gratis with the sensitivity disks by the detail man.—Michael W. Rytel, MD, Chief, Section of Infectious Diseases; Associate Professor of Medicine, The Medical College of Wisconsin, Milwaukee □

What to do until suppositories work:





Actually, on the average, evacuant suppositories take about an hour to work.[1-3] Sometimes two.[4] Sometimes more.[3] Also, suppositories can be ineffective in up to 38% of patients,[5] and not infrequently produce smarting, burning and tenesmus.[6]

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Warning: Frequent or prolonged use of enemas may result in dependence. Take only when needed or when prescribed by a physician. Do not use when nausea, vomiting or abdominal pain is present.
Caution: Do not administer to children under two years of age unless directed by a physician.

References: 1. Blumberg, N.: Med Times 91:45, Jan., 1963. 2. Sweeney, W. J., III: Amer J Obstet Gynec 85:908, Apr. 1, 1963. 3. Weinsaft, P.: J Amer Geriat Soc 12:295, Mar., 1964. 4. Baydoun, A. B.: Amer J Obstet Gynec 85:905, Apr. 1, 1963. 5. Feder, I. A., Flores, A. and Weiss, J.: Amer J Gastroent 33:366, Mar., 1960. 6. Smith, J. J. and Schwartz, E. D.: Western J Surg 72:177, May-June, 1964.

F19A71

MINUTES OF COUNCIL MEETING

MILWAUKEE, MAY 8, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 7:30 pm on Saturday, May 8, 1971, at the Hotel Pfister in Milwaukee.

Voting members present: Doctors Schrank, Galgano, Huth, Nordby, Edwards, Smejkal, Dettmann, Mauthe, Rohde, Boren, Ludwig, Manz, Doyle, Chojnacki, Foley, Schmidt, Egan, Past President Callan, President McRoberts, and Speaker Nereim.

Other officers and guests: President-elect Behnke; Vice-speaker Hamlin; AMA delegates and alternates Bell, Galasinski, Hildebrand, Picard, Fox, Carlson, Russell, Kief; Doctors Bernhart, Dessloch, Stahmer, Finlayson, Bein, Handy.

Staff and consultants: Messrs. Thayer, Koenig, Brower, Maroney, Reynolds, Johnson, LaBissoniere; Mrs. Anderson and Miss Pyre; Messrs. Crownhart, Gill, Murphy, Kluwin, Tiffany.

2. Approval of Minutes

On motion of Doctors Foley–Galgano, carried, minutes of the March 27–28, 1971, meeting were approved.

3. Election of Commission on State Departments

By various motions, the following were reelected to the Commission on State Departments:

General chairman: T. W. Tormey, Jr., MD

Vice-chairman: W. J. Egan, MD

Division chairmen: Craig Larson, MD, Aging
D. A. Treffert, MD, Alcoholism & Addiction
H. A. Anderson, MD, Chest Diseases
Meyer S. Fox, MD, Ear, Nose & Throat
John J. Suits, MD, Handicapped Children
F. J. Hofmeister, MD, Maternal & Child Welfare
E. E. Houfek, MD, Nervous & Mental Diseases
P. A. Dudenhoefer, MD, Rehabilitation
J. C. H. Russell, MD, School Health
George Nadeau, MD, Vision

4. Late Resolutions

A. Councilor Chojnacki requested Council transmittal of three resolutions to the House of Delegates:

FF—Senate Bill No. 2 concerning dispensing of contraceptives

On motion of Doctors Egan–Doyle, carried, this was forwarded to the House.

GG—Abortion

On motion of Doctors Foley–Mauthe, carried, this was forwarded to the House of Delegates without any statement of position by the Council.

HH—Chiropractic

On motion of Doctors Edwards–Schrank, carried, this resolution was accepted for transmittal to the House.

B. The Barron–Washburn–Sawyer–Burnett County Medical Society requested introduction of two resolutions through Councilor Manz:

Preschool eye and ear testing; encouragement of Woman's Auxiliary

On motion of Doctor's Schrank–Doyle, carried, this was forwarded to the House as Resolution JJ.

Contingency fees in malpractice suits

On motion of Doctors Schmidt–Mauthe, carried, this was forwarded as Resolution KK without comment.

C. Councilor Schmidt requested introduction of one resolution endorsing "Medicredit"

On motion of Doctors Chojnacki–Doyle, carried, this was forwarded to the House as Resolution MM.

D. Doctor Nordby stated that the Dane County Medical Society wished a substitute introduced for Resolution L, which had been distributed, in reference to HEW regulations on services provided patients in nursing homes.

In the belief that it is the prerogative of the reference committee to recommend a substitute if it wished, the new text was forwarded as Resolution LL on motion of Doctors Mauthe–Foley, carried.

5. Annual Report of Treasurer

On motion of Doctors Foley–Galgano, carried, the report of Treasurer Weston was accepted for distribution to the House.

6. Progress Report on Professional Liability

Mr. Kluwin reported on the continuing contacts from members on questions related to professional liability, and of his meeting with the Insurance Commissioner in reference to the possibility of following the Pennsylvania approach to resolving problems of liability insurance coverage and adjudication of suits. He said that while he personally favors abolition of contingency fees, he planned to appear before the appropriate reference committee on the resolution just forwarded and advise that it is untimely in light of other important legislation which has been introduced in Wisconsin limiting the amount of recovery and the time for institution of suit.

7. Request of Gundersen Clinic

The Council was advised of correspondence from and in behalf of the Gundersen Clinic requesting assistance in a proposed reorganization of the Clinic, Adolf Gundersen Medical Foundation, and Lutheran Hospital as a public foundation.

Following discussion, and on motion of Doctors McRoberts–Mauthe, carried, the Council asked that the Clinic be informed that the Society will watch the matter with interest, and at such point in the development as questions of an ethical nature may arise, it will be glad to advise on this aspect.

8. Annual Report on Conflict of Interest

Mr. Thayer reported that all of those elected last May had signed the individual certificate form on conflict of interest, and reminded councilors and officers that once signed, it is up to the individual to notify the Secretary of "any future situation, activity or investment concerning which a possible conflict of interest might arise."

9. Report of Executive Committee

Doctor McRoberts reported as follows on the afternoon meeting of the committee:

A. Standing Committee Appointments

According to custom, President-elect Behnke discussed with the committee his proposed appointments to standing committees which will be made at the first session of the House with its consent.

B. Council Committee Appointments

The Chairman of the Council announced the following appointments to commissions created by the Council:

(1) *Commission on Health and Natural Resources*

Anne E. Roethke, MD, Milwaukee, to succeed O. A. Sander, MD

W. H. Thiede, MD, Wauwatosa, to an unexpired term

(2) *Commission on Safe Transportation*

Anthony Herrmann, MD, Racine, to a vacancy

C. Advisors to Wisconsin State Medical Assistants Society

The committee reported appointment of the following as advisors to the WSMAS for the ensuing year:

R. M. Baldwin, MD, Beloit
Rodrigo A. Munoz, MD, Sheboygan
W. D. James, MD, Oconomowoc
C. E. Oberdoerfer, MD, Racine

D. Statement on Prepaid Plans

The following "Policy Statement Concerning Alternative Methods of Organizing and Financing Health Care" was distributed to the Council and recommended by the committee. It was adopted on motion of Doctors McRoberts–Smejkal, carried:

"Exploring and implementing 'new' methods of delivering and paying for health services has been a mark of the State Medical Society of Wisconsin for nearly four decades. Experience with these activities makes it clear there is no single 'best' method to provide health care considering the many factors of medical manpower, geography, educational levels, and social, ethnic, and economic problems. It is necessary, therefore, to continue to recognize and encourage multiple methods for delivering medical and other health services.

"The State Medical Society now, as in the past, should inspire, participate in, and provide leadership for new ways to improve the delivery of quality medical care at reasonable cost for all the people of Wisconsin. This includes affirmative response to professional and nonmedical groups seeking the help of the Society and its WPS–Blue Shield program in the development of prepaid group programs, cooperative plans, or other mechanisms with potential for improving the financing and delivery of health services.

"In the process of moving from assumption to recognized data through objective experimentation, the Council recommends that the Society and its WPS–Blue Shield plan be guided by the following previously adopted principles:

"(1) The Council statement of July 20, 1968, relating to pilot health insurance programs

"(2) The Statement of Objectives of the Wisconsin Plan and Conditions for Participation by Private Carriers, December 1951

"(3) The principles set forth in the Cooperative Sickness Care Act, Wisconsin Statutes, 185.981–185.985, in the development of which the Society participated in 1947.

"The Council believes that these guiding statements* represent sound policy which in large measure continues to be applicable to current developments for the delivery of health care.

"Finally, the Council recommends that in areas where experimental or innovative programs are to be offered, all members of the county medical society be informed of the plan and be given the opportunity to participate to the extent practicable."

* Not quoted here as they are already on record.

E. Oath of Office

On motion made, seconded and carried, the Council approved abbreviation of the original oath of office as proposed by the committee.

F. Consumer Health Education Project

The committee reported receipt of information on this project which may be conducted in one of the counties of Eau Claire, Shawano, Waukesha or Waushara providing a grant is received from HEW by the University of Wisconsin Extension Division, and providing further that one of these county societies chooses to participate. This proposed project is also described in the report of the Commission on Health Information to be distributed to the House at its first session.

G. Emergency Health Personnel Act of 1970

The Wisconsin Chapter of SAMA had asked Doctor Callan to introduce a resolution relative to this act of Congress, and the Executive Committee presented it to the Council in revised form, believing that further study was indicated.

On motion of Doctor Mauthe, seconded and carried, the Council forwarded the revision to the House as Resolution II.

H. Separate Health Care Review Organization

A report and recommendations of the Society attorneys had been mailed to the Council. These were discussed by the Executive Committee, which recommended approval of the Council and forwarding to the House of Delegates.

The recommendations were:

(1) The Council authorize the establishment of a nonstock, nonprofit corporation described . . . for purposes of brevity as a "foundation," to handle peer review, utilization review and other submitted matters involving health care contracts which are in addition to those between patients, physicians, other providers and health institutions.

(2) If the Council concludes that it is preferable to first refer the matter to the House, that it ask the House for authority to establish a "foundation" for the functions enumerated in Recommendation I, together with such other functions as may be determined to be essential or advisable.

(3) The Council arrange the initial financing required by such organization, and assign a survey of this matter to the Finance and Executive Committees of the Council, with authority to act.

(4) Such organization to have such staff and facilities as may be required, including a physician as its director.

(5) The Executive Committee be requested to circulate the proposed organizational structure and initial financial needs of such organization to the full Council for mail approval at the earliest feasible date.

On motion of Doctors Egan–Schrank, carried, the Council approved the recommendations and forwarded them with the report to the House of Delegates.

I. Health Maintenance Organization

A report and recommendations of the Society attorneys on this subject had also been mailed to the Council and discussed by the Executive Committee, which recommended that the Council and Commission on Medical Care Plans be authorized to set up the structure for a health maintenance organization to be utilized when it becomes necessary.

On motion of Doctors Dettmann–McRoberts, carried, the matter was referred to the Commission on Medical Care Plans for further analysis and report back to the Council, this action to be reported to the House.

10. Councilor District Reports

All councilors present reported on conditions in their districts as required in the Bylaws. Several announced this would be their last meeting attended as councilor, and were thanked for their services.

11. Editorial Director of *Wisconsin Medical Journal*

Three individuals were nominated for a one-year term as Editorial Director and Raymond Headlee, MD, Elm Grove, was elected.

12. Finance Committee

Doctor Nordby reported that the committee had met to review budget performance for the first quarter of 1971, and had received copies of the complete audits of all Society activities. These are available at the Society for any councilor who wishes to see them.

13. Board of Health and Social Services

Doctor Nordby asked councilors to consider, before the meeting to be held after adjournment of the House on May 11, the names of physicians for submission to Governor Lucey for appointment to a term expiring on this Board.

14. Adjournment

The meeting adjourned at 10:35 pm

EARL R. THAYER
Secretary

Approved:
E. J. NORDBY, MD
Chairman

MINUTES OF COUNCIL MEETING

MILWAUKEE, MAY 11, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 10:30 am on Tuesday, May 11, 1971, at the Pfister Hotel in Milwaukee.

Voting members present: Doctors Schrank, Galgano, Huth, Nordby, Edwards, Smejkal, Dettmann, Mauthe, Rohde, Heinen, Lewis, Manz, Doyle, Pittelkow, Foley, Schmidt, Egan, Meyer, Past President McRoberts, President Behnke, and Speaker Nereim.

Officers and others present: President-elect Purtell, Vice-speaker Hamlin; Doctors Simenstad, Carlson (late), Bernhart, Hollenbeck, Bein; Messrs. Thayer, Koenig, Doran, Kluwin; Mrs. Anderson and Miss Pyre.

Guests present: J. Ernest Breed, MD, President, Illinois State Medical Society; Sidney Adler, MD, President-elect, Michigan State Medical Society; L. J. O'Brien, MD, President, Iowa Medical Society; R. J. Jackman, MD, President, Minnesota State Medical Association; and P. R. Petrich, MD, President-elect, Indiana State Medical Association.

2. Oath of Office

Doctor Nordby administered the oath of office to President-elect Purtell and newly elected Councilors Heinen, Lewis, Pittelkow, and Meyer.

3. Elections

By separate motion duly made, seconded and carried, the following were elected for the ensuing year:

Chairman of the Council: E. J. Nordby, MD

Vice-chairman: J. E. Dettmann, MD

Treasurer of the Society: F. L. Weston, MD

Assistant Treasurers: H. Kent Tenney, MD, A. A. Quisling, MD, N. A. Hill, MD, J. T. Sprague, MD, and R. A. Sievert, MD

4. Board of Health and Social Services

The names of three physicians were submitted for nomination to the Governor for his consideration in making an appointment to this Board.

5. Remarks by Visiting Officers

Each of the officers of neighboring state medical societies spoke to the Council, confining their remarks for the most part to activities in the area of peer and utilization review.

6. Legislative Report

Mr. Thayer gave an up-to-the-minute report on the status of several bills in the Legislature, including those involving chiropractic, and the physician's assistant bill. A communication had been prepared, following action by the House, expressing concern about the future of the medical schools.

7. Next Meeting

Doctor Nordby affirmed that the next meeting will be in Madison on July 31, continuing on August 1 as necessary. He asked councilors to forward any suggestions they have for inclusion on the agenda if appropriate.

8. Adjournment

The meeting adjourned at 11:30 am

EARL R. THAYER
Secretary

Approved:
E. J. NORDBY, MD
Chairman

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SECTION OPHTHALMOLOGY

SEPTEMBER 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

SAFETY LENSES FOR ALL

The Food and Drug Administration (FDA) has ordered effective Dec. 31, 1971 that "all glasses and sunglasses must be made of impact-resistant lenses, except in those cases where the physician or optometrist finds that such lenses will not fulfill the visual requirements of the particular patient, directs in writing the use of other lenses, and give written notification thereof to the patient." Contact lenses are not covered by the FDA regulation.

The new regulation requires that all glasses sold in the U.S., prescription and non-prescription, be made of laminated glass, heat-tempered glass, or plastic lenses.

The FDA *Final Order* allows the physician or optometrist the option of prescribing heat-treated glass lenses, plastic lenses, laminated glass lenses, or glass lenses made impact-resistant by other methods.

The regulation does not include a requirement that eyeglass frames be constructed of flame-resistant materials. Although American manufacturers have abandoned such unsafe frame materials as cellulose nitrate, foreign-made frames of these flammable materials continue to be imported.

NEW OPHTHALMOLOGIST IN WAUSAU

J. M. Hattenhauer, MD has joined MDs G. L. Backer, W. D. Backer, L. J. Rossman, and C. F. MacCarthy in the practice of ophthalmology in Wausau.

Doctor Hattenhauer did his undergraduate work at Marquette University in Milwaukee. He attended medical school at the University of Illinois in Chicago, graduating in 1964. His internship was spent at Ancker Hospital (now St. Paul Ramsey Hospital) in St. Paul, Minn. From 1965 to 1967 Doctor Hattenhauer was a general medical officer in the U.S. Army Medical Corps at Fort Dix, N.J. He attended the Harvard Postgraduate School of Medicine Basic Science course in ophthalmology in Boston from August to December 1967. He then served his residency in ophthalmology at the University of Illinois Eye and Ear Infirmary in Chicago from January 1968 until June 1971. The last six months of his residency were spent organizing and running a macular consultation service including evaluations of fluorescein angiography.

RETINA FELLOW AT UW

James Harris, MD recently began a one-year retina fellowship with Matthew D. Davis, MD in the Department of Ophthalmology at the University of Wisconsin Medical Center. Doctor Harris completed his ophthalmology residency at the University of California in June 1971. His work with Doctor Davis in diabetic retinopathy and retinal detachment surgery is sponsored by the National Institutes of Health.

MILWAUKEE OPHTHALMOLOGICAL SOCIETY

The 1971–1972 scientific program of the Milwaukee Ophthalmological Society has been announced as follows:

Oct. 26: Francis A. L'Esperance, Jr., MD—*Laser Photo-coagulation.*

Nov. 23: Edward W. D. Norton, MD and Robert Machemer, MD—*A New Approach to Vitrectomy.*

Jan. 25: James A. Kingham, MD—*Report on his research.*

Feb. 22: Morton F. Goldberg, MD—*Clinical Genetics and Genetic Counseling.*

Mar. 28: B. Thomas Hutchinson, MD—*Office and Operative Gonioscopy.*

Apr. 25: *Dyslexia.* Combined meeting with educators. Speaker unconfirmed.

May 11: Herbert E. Kaufman, MD—State Medical Society of Wisconsin and Section on Ophthalmology meetings.

Any Wisconsin ophthalmologist who is not a member of the Society is welcome to attend these sessions which are held at the University Club in Milwaukee. Reservations should be made with Society president, Howard W. Fiedler, MD, 2040 West Wisconsin Ave., Milwaukee, Wis. 53233; or tel. 414/342–5070.

MEDICAL COLLEGE EYE RESEARCH GRANT

The Medical College of Wisconsin has announced receipt of a grant of $5,000 from Research to Prevent Blindness (RPB), of New York City to support and accelerate intensive studies of the eye and its diseases.

The award to the Medical College's Department of Ophthalmology is unrestricted and is renewable each year. It provides the department with an unusual resource of fluid funds, enabling it to respond immediately to scientific needs and opportunities as they occur.

Research to Prevent Blindness, a national voluntary foundation, has provided the Medical College with a total of $10,000 in unrestricted grants over the past two years.

DATES TO REMEMBER

Oct. 9–10: Wisconsin–Upper Michigan Society of Ophthalmology and Otolaryngology, Lake Delton.

NEWS HIGHLIGHTS

State Pathologists to Meet Oct. 23

Members of the Wisconsin Society of Pathologists will meet Saturday, October 23, at the Madison Veterans Administration Hospital Auditorium (West end of VA Hospital) for their annual fall session.

J. M. B. Bloodworth, Jr., MD* of Madison, program chairman, has announced the tentative program as follows:

MORNING PROGRAM, 10 am to noon—

(a) Application of Immunochemical Techniques to Pathology—Peter Burkholder, MD, professor in Department of Pathology, University of Wisconsin (UW) Medical Center, Madison.

(b) Significance of Mycoplasma, Related Organisms and "L" Forms of Bacteria in Human Disease—E. M. Lapinski, MD, chief of microbiology, VA Hospital; and professor of medical microbiology, UW Medical Center.

(c) Ectopic Production of Hormones by Nonendocrine Gland Tumors—J.M.B. Bloodworth, Jr., MD,* chief of laboratory service, VA Hospital; and professor in Department of Pathology, UW Medical Center.

(d) Bronchial Brush Techniques in Diagnosis of Lung Lesions—Walter H. Thiede, MD* of St. Luke's Hospital, Milwaukee; and professor in the Medical College of Wisconsin, Milwaukee.

LUNCHEON, at VA Hospital.

AFTERNOON SEMINAR, 1:00 pm—

Pathology of the Lung—John P. Wyatt, MD, professor and chairman, Department of Pathology, University of Manitoba, Canada.

BUSINESS MEETING, 4:30 pm.

PREPRANDIAL HOUR AND DINNER, French Quarter, 6:00 pm.

WOMEN'S PROGRAM—Trip to Spring Green with lunch at Spring Green Restaurant and visit to House on the Rock and Taliesen East, Frank Lloyd Wright's home.

Officers of the Wisconsin Society of Pathologists are: president, William G. Richards, MD* of Beaver Dam; president-elect, Chesley Erwin, MD* of Elm Grove; vice-president, M. D. Blackburn, MD* of Green Bay; secretary, Roland C. Brown, MD* of Milwaukee; and treasurer, Donald J. Stevenson, MD* of Madison.

La X Pediatrician Heads Six-State Perinatal Group

A pediatrician with the Gundersen Clinic in La Crosse was recently elected to a two-year term as president of the newly formed Great Plains Association for Perinatal Health Care.

He is J. Michael Hartigan, MD,* a native of Fort Wayne, Ind., who received his medical degree from Upstate Medical School, State University of New York, in 1963.

His internship and residency training were taken at the Ohio State University Hospital and Columbus Children's Hospital. He was a clinical instructor in the Department of Pediatrics at Ohio State College of Medicine before entering the U.S. Air Force in September 1967. After completing military duty in September 1969, he joined the Gundersen Clinic.

The Great Plains perinatal association is believed to be the first of its kind in the country. Its membership includes 240 pediatricians obstetricians, nurses, medical and nursing educators, family practitioners, and maternal and child health representatives.

The group includes representatives from Wisconsin, Nebraska, Minnesota, Iowa, North Dakota, and South Dakota. The organization's purpose is to improve the health care of the expectant mother, the fetus, and the newborn infant.

The group is presently making plans to develop regional health care centers within the organization's boundaries.

PHYSICIAN BRIEFS

John M. Kirsch, MD

. . . Monroe, has joined the medical staff of The Monroe Clinic. A graduate of the University of Illinois Medical School, he interned at Illinois Research and Education Hospital. He was a flight surgeon in the U. S. Army Air Force and spent a year in Vietnam. After military service, he studied for a year in the Marquette medical school's affiliated program of general surgery and finished his residency at the University of Illinois.

Howard Axenrod, MD

. . . Green Bay, recently joined the medical staff of the West Side Clinic, Green Bay. A graduate of Catholic University of Louvain, Belgium, he served his internship at the Lutheran Medical Center in New York City and did his residency at Winnipeg General Hospital, Winnipeg, Manitoba, Canada. Doctor Axenrod has spent the last two years specializing in urology in St. Boniface Hospital, Winnipeg.

William B. Frey, MD

. . . Monroe, recently joined the department of pediatrics at The Monroe Clinic. He is a graduate of the University of Minnesota Medical School and did his residency at Milwaukee County Hospital, Milwaukee Children's Hospital, and the University of Minnesota Hospitals. Doctor Frey has been in private practice in South Bend, Ind., for 22 years.

Hendrik Leering, MD*

. . . Lake Mills, recently was appointed chairman of the Jefferson County Family Counseling Center for one year.

William T. Mautz, MD*

. . . Eau Claire, recently was elected chief of the medical staff at Sacred Heart Hospital in Eau Claire.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

John D. Swingle, MD*

. . . has joined the Department of Radiology of Gundersen Clinic, Ltd. and La Crosse Lutheran Hospital in La Crosse. He was born in Richland Center where he attended the public schools and graduated from high school in 1949. Doctor Swingle attended the University of Wisconsin Medical School, obtaining his MD degree in 1956. His internship was served at Montreal General Hospital, Canada, from 1956 to 1957. He served his military obligation from 1958 to 1960 after which he established a general practice in Port Washington. From 1962 to 1965 he fulfilled a residency training in radiology at University Hospitals, Madison. He served as associate professor of radiology at University Hospitals from 1965 to 1971.

Donald J. Carek, MD*

. . . Elm Grove, has been elected president of the medical staff of Milwaukee Psychiatric Hospital, Wauwatosa. He succeeds Raymond Headlee, MD* of Elm Grove. Both are members of the associate attending staff of the hospital.

William L. Lorton, MD*

. . . Wauwatosa, has been elected secretary of the medical staff of Milwaukee Psychiatric Hospital, Wauwatosa. He succeeds Steven V. Hansen, MD,* Wauwatosa. Doctors Lorton and Hansen are members of the active medical staff of the hospital.

Richard D. Stewart, MD*

. . . professor and chairman of the Department of Environmental Medicine at the Medical College of Wisconsin, Milwaukee, has been appointed to the Committee on Toxicology of the National Research Council. The Committee advises federal agencies on questions relating to the health hazards for military and civilian personnel from the toxic properties of materials proposed for use by the sponsors.

Louis J. Kurten, MD*

. . . a founding member of the Kurten Medical Group, Racine, recently retired from private practice and moved to Fayetteville, N. C., where he is chief of the department of internal medicine at the Veterans Administration Hospital. A graduate of Northwestern Medical School in 1940, he served as clinical instructor in medicine at Marquette University School of Medicine for three years, served in the United States Navy, after which he joined his brother Russell M. Kurten, MD, who died in 1966, in practice. The Kurten Medical Group was founded in 1952. Doctor Kurten was president of the Racine County Medical Society in 1959 and was a delegate for the Section on Internal Medicine of the State Medical Society.

Weston W. Jones, MD*

. . . Portage, recently was elected chief of the medical staff of the Divine Savior Hospital and Nursing Home in Wisconsin Dells.

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Robert D. Holmstrom, MD

. . . Sheboygan, recently became associated with Robert Pointer, MD,* Sheboygan, in the practice of ophthalmology. Doctor Holmstrom graduated in 1962 from Emory University Medical School, Atlanta, Ga., and served a one year internship at Presbyterian St. Luke's Hospital, Chicago. He joined the United States Navy as a flight surgeon and from 1966–1969 spent three years in residency in ophthalmology at the Naval hospital, San Diego, Calif.

Edwin L. Overholt, MD*

. . . La Crosse, recently returned from Aspen, Colo., where he presented a lecture on the "Internal Manifestations of External Disorders." Doctor Overholt, in conjunction with his lecture, discussed "Internal and Psychosomatic Medicine." He is the director of medical education and research at the Gundersen Clinic.

Paul Z. Han, MD

. . . Wausau, recently joined the staff of the Stahmer Clinic in Wausau. He is a graduate of the University of Illinois, College of Medicine, Chicago, and was awarded the Abbott Award for excellence in medical student research. Doctor Han served his internship at Duke University Medical Center, Durham, N.C., and is also a diplomate of the National Board of Medical Examiners.

John J. Kief, MD

. . . recently became associated with the Bump Medical Group in Rhinelander. Doctor Kief graduated from Marquette University School of Medicine in 1965 and served his internship at Madigan General Hospital, Fort Lewis, Wash., followed by a residency in internal medicine at William Beaumont General Hospital, El Paso, Tex. Doctor Kief has been with the U. S. Army Medical Corps and recently completed his last assignment as chief of the department of medicine and outpatient clinics at Munson Army Hospital, Fort Leavenworth, Kan. His father is H. J. Kief, MD* of Fond du Lac, a past president of the State Medical Society of Wisconsin.

Deaconess Hospital Forms New Clinic to Help Patients with Cardiac Pacemakers

Deaconess Hospital in Milwaukee recently announced formation of a clinic where patients with cardiac pacemakers will have the devices monitored electronically on a regular schedule. Its formal opening was July 28.

According to James T. Botticelli, MD,* chief of medicine and director of cardiovascular diseases, patients of the new clinic will be seen at three-month intervals for 18 months after their pacemaker is implanted. After this time they will be seen monthly.

In addition, if there is any indication of rate change, the patient will be checked weekly or daily through a telephone system, he stated.

"To our knowledge, this will be the only pacemaker clinic in the midwest," Dr. Botticelli said. "We anticipate at least 150 patients will be served initially." The patient's private physician will receive written reports of the electronic pacemaker analysis, he explained.

State Dermatologists Hold Summer Session

Over 70 dermatologists and their guests attended the Summer Scientific Program of the Wisconsin Dermatological Society at the Pioneer Inn in Oshkosh, August 6 to 8.

The program included some of the best known dermatologists in the nation: Harvey Blank, MD of University of Miami; Earle W. Brauer, MD, vice-president of medical affairs for the Revlon Research Center in New York City; Howard I. Maibach, MD of the University of California at San Francisco; Harold O. Perry, MD of the Mayo Clinic, Rochester, Minn.; and Henry H. Roenigk, Jr., MD of the Cleveland Clinic.

Wisconsin dermatologists participating in the program included Robert R. Baumann, MD* of The Monroe Clinic and Marvin S. Kagen, MD* of Appleton.

Following the banquet on August 7, Doctor Brauer delighted and amazed his audience of 120 dermatologists and their wives with his after-dinner talk on cosmetics, particularly the techniques and problems accompanying coloring and dyeing of the hair.

Officers of the Wisconsin Dermatological Society are: president, William F. Schorr, MD* of Marshfield; vice-president, Robert R. Baumann, MD* of Monroe; and secretary–treasurer, Hubert V. Moss, MD* of Madison.

Milwaukee Industrialist Gives $1 Million to Medical College

Earlier this year a retired Milwaukee industrialist, Evan P. Helfaer, made a gift of $1 million to the Medical College of Wisconsin, Milwaukee.

Robert S. Stevenson, board chairman of the school, said the money would be used entirely for a new medical education building, the building to be constructed on the grounds of the Milwaukee County Institutions in suburban Wauwatosa as part of the Southeastern Wisconsin Medical Center.

Total cost of the building is estimated at $28 million, of which $9 million is to be raised locally.

Mr. Helfaer was the principal owner of Lakeside Laboratories, a Milwaukee-based pharmaceutical company which was sold to Colgate–Palmolive in 1959.

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Howard Mauthe, MD*

. . . Fond du Lac, recently was featured as the prosecutor in the James Baldwin play, "Blues for Mr. Charlie," which was shown at the Pabst Theater in Milwaukee in June. The cast was drawn from Milwaukee's inner city, its suburbs, and other Wisconsin communities. The University of Wisconsin–Milwaukee School of Fine Arts and the People's Theater collaborated in producing the Baldwin drama which was inspired by the death of Medgar Evers.

John P. Carson, MD

. . . Marshfield, recently joined the staff of the Marshfield Clinic. An internist, Doctor Carson graduated from the Cincinnati Medical School in 1962 and interned at St. Elizabeth Hospital, Youngstown, Ohio. After completing two years in the Army Medical Corps, he began a residency and fellowship at Cincinnati General Hospital. For the past two years, he has been in private practice with the Missouri Valley Clinic, Bismarck, N. D.

Richard B. Stafford, MD*

. . . Menasha, who has been associated with the Winnebago State Hospital for the past six years, recently joined the department of psychiatry at the Riverside Clinic. He served as assistant clinical director in charge of the children and adolescent unit at Winnebago. A graduate of the University of Wisconsin Medical School, he did his internship at St. Joseph's Hospital, Marshfield, and residency at the University Hospitals, Madison. He is certified by the American Board of Neurology and Psychiatry.

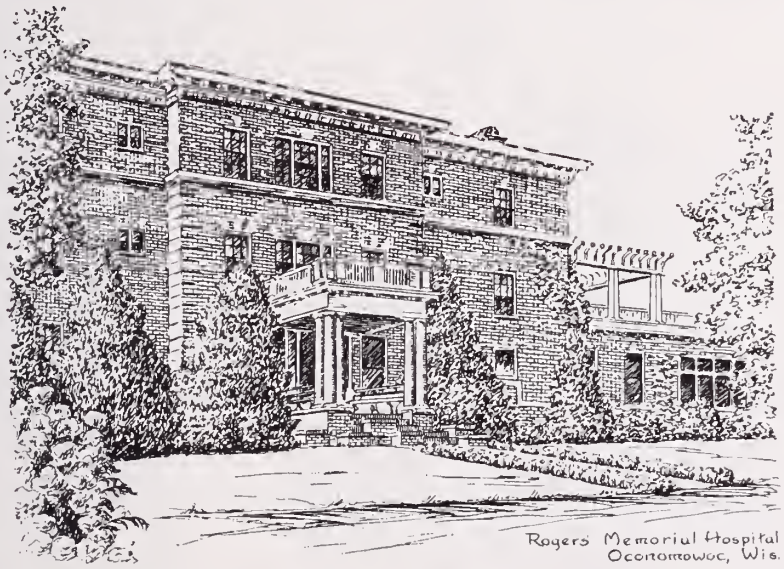
Thomas E. Buie, Jr., MD
Thomas N. Roberts, MD

. . . La Crosse, have joined the departments of psychiatry and pediatrics, respectively, at the Gundersen Clinic and La Crosse Lutheran Hospital. Doctor Buie is a graduate of Bowman Gray of Wake Forest, Winston–Salem and served his internship at North Carolina Baptist Hospital at Winston–Salem. He fulfilled his residency training at Dorothea Dix Hospital, Raleigh, N.C..

Doctor Roberts

Doctor Buie

Doctor Buie also served as a consultant to the Edge Combe–Nash Mental Health Clinic, Rocky Mountain, N.C., as director of residency training and assistant unit director at Dorothea Dix Hospital. He also was the director of the Mental Health Division, Student Health Service, and assistant professor in the department of psychiatry at the University of Kentucky Medical Center in Lexington. Doctor Roberts graduated from the University of Wisconsin Medical School in 1968 and served his internship at La Crosse Lutheran Hospital and Gundersen Clinic. His residency training was taken at University Hospitals, Madison.



MEDICAL STAFF

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Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

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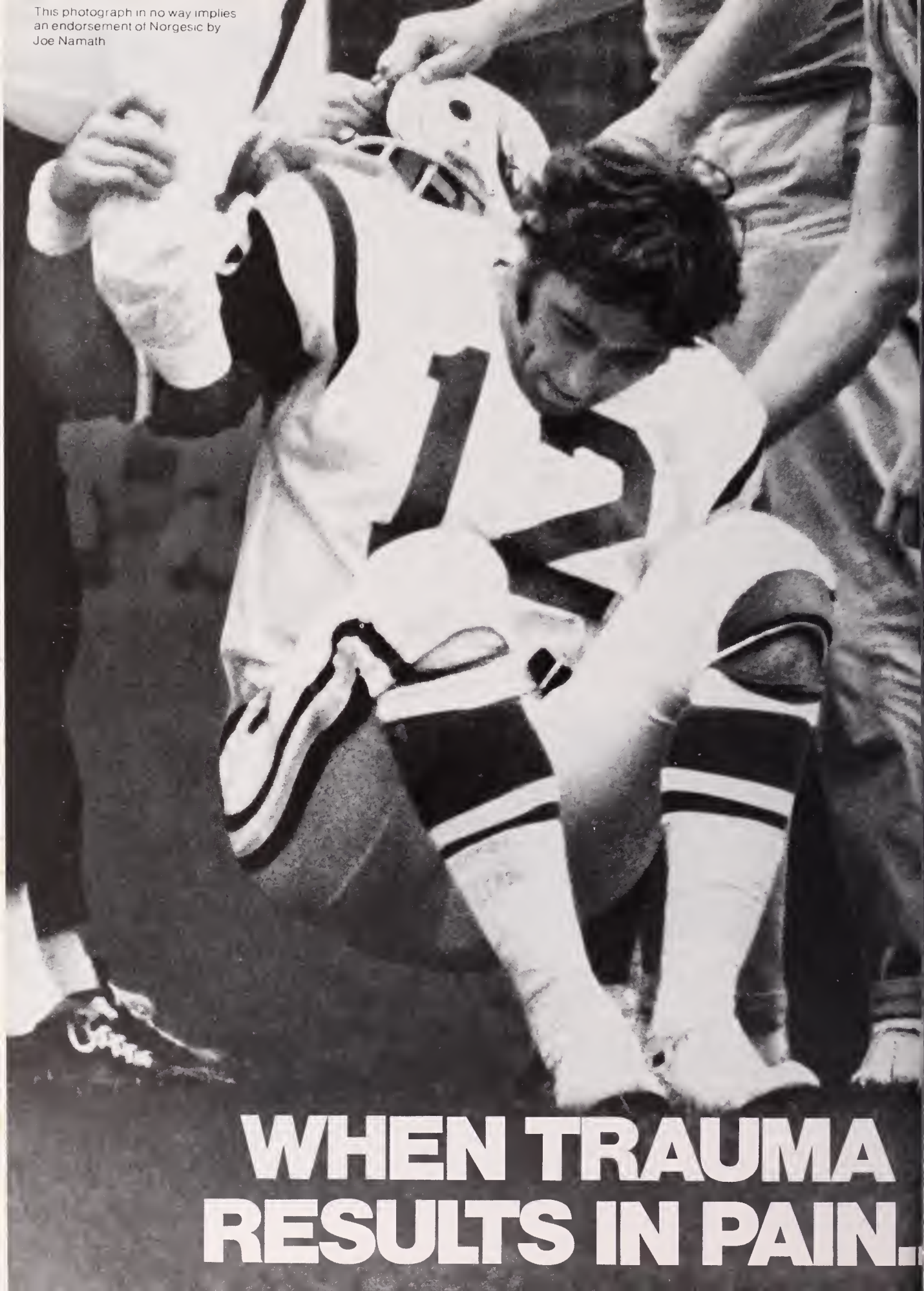
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Contraindications: Because of the mild anticholinergic effect of orphenadrine, Norgesic should not be used in patients with glaucoma, pyloric or duodenal obstruction, achalasia, prostatic hypertrophy or obstructions at the bladder neck. Norgesic is also contraindicated in patients with myasthenia gravis and in patients known to be sensitive to aspirin, phenacetin or caffeine.
Since mental confusion, anxiety and tremors have been reported in patients receiving orphenadrine and propoxyphene concurrently, it is recommended that Norgesic not be given in combination with propoxyphene (Darvon®).
Warnings: USE IN PREGNANCY: Since safety of the use of this preparation in pregnancy, during lactation, or in the child-bearing age has not been established, use of the drug in such patients requires that the potential benefits of the drug be weighed against its possible hazard to the mother and child.
USE IN CHILDREN: The safe and effective use of this drug in children has not been established; therefore, the physician must weigh the benefits against the potential hazards.
Precautions: It has been reported that prolonged or excessive use of phenacetin may result in nephrotoxicity. Caution, therefore, should be exercised when Norgesic is administered to patients with renal disorders. It should also be used with caution in patients with tachycardia.
Adverse Reactions: Side effects of Norgesic are those seen with APC or those usually associated with mild anticholinergic agents. These may include tachycardia, palpitation, urinary hesitancy or retention, dry mouth, blurred vision, dilatation of the pupil, increased intraocular tension, weakness, nausea, vomiting, headache, dizziness, constipation, drowsiness, and rarely, urticaria and other dermatoses. Infrequently an elderly patient may experience some degree of confusion. Mild central excitation and occasional hallucinations may be observed. These mild side effects can usually be eliminated by reduction in dosage. One case of aplastic anemia associated with the use of Norgesic has been reported. No causal relationship has been established.
Dosage and Administration: Adults—1 to 2 tablets 3 to 4 times daily.

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James Kuplic, MD

. . . Sheboygan, recently joined the staff at Sheboygan's Medical Arts Building. Doctor Kuplic graduated from the University of Wisconsin Medical School in 1967 and has been serving his internship and residency at St. Luke Hospital, Cleveland. He is a candidate-member of the American College of Physicians and is a captain in the National Guard, serving as commanding officer of a medical corps company in Cleveland.

Pedro B. Fernandez, MD

. . . Sheboygan, recently joined the staff of the Family Medical Center, Sheboygan. A graduate of the Far Eastern University, Manila, The Philippines, Doctor Fernandez served his internship at Evangelical Deaconess Hospital, Milwaukee, and his residency training at Norwegian–American Hospital, Chicago, and the Scott and White Clinic, Temple, Tex. He recently completed a year at Mount Sinai Medical Center in Milwaukee, where he was house officer in the department of OB–GYN.

Michael L. McCann, MD*

. . . Middleton, recently opened his office in pediatrics in Middleton. A graduate of Cleveland Medical School, he was on the faculty of Western Reserve in Cleveland. Doctor McCann was at the University of Wisconsin at St. Mary's Hospital and was associated with Associated Physicians in Madison. Prior to opening his own office, he was with the Dean Clinic in Madison.

William H. Schuler, MD*

. . . Ripon, recently was honored for his services as Badger Boys State camp physician for the past 25 years. Doctor Schuler was presented with a pin for his many years of service to the Boys State organization. He also has served as college physician for Ripon College.

Wallace G. Irwin, MD*

. . . Lodi, president of the medical staff of Divine Savior Hospital and Nursing Home, Inc., Portage, recently was appointed a member of the board of directors of the Home.

R. M. WALDKIRCH, MD* of De Pere holds a rose and a plaque he received recently as recipient of the De Pere Rotary Club's annual "Roses for the Living" award. The honor was in recognition of Doctor Waldkirch's outstanding community service in the field of medicine and as a businessman. Mrs. Waldkirch shared the occasion with her husband. (Photo courtesy De Pere Journal)

Winnebago State Hospital Adds Five Physicians

Five new physicians recently were added to the medical staff of Winnebago State Hospital. MDs Shujat Barney, Glen Shaurette, Albert Finney, and Kwo Hwa Tseng are psychiatrists and Lee H. Brown, a general practitioner.

Doctor Barney took his residency at the Mental Health Institute, Independence, Iowa, and Doctor Finney is a graduate of Colorado School of Medicine and did residency training at the Gulfport, Miss., Veterans Administration Hospital. Doctor Shaurette graduated from Creighton University School of Medicine, Omaha, Neb., and took his residency at the University of Wisconsin Medical School in Madison. Doctor Tseng is a graduate of Taiwan's National University College of Medicine and also took residency training at UW Medical School. Doctor Brown was educated at Miami University and the Ohio University College of Medicine.

ORDERS NOW BEING TAKEN FOR THE 1971

CHRISTMAS CARDS

FEATURING

Evergreen Park Cottage Sanatorium

A historical marker in the village of Lake Nebagamon, in Douglas County, reads in part: "Here in 1903, Doctor W. B. Hopkins, Cumberland, opened the first tuberculosis sanatorium in Wisconsin. He built an office and three one-story frame buildings with screen sides. . . . Hopkins treated tuberculosis cases here in the summer. He wrote of the "pure air, day and night" and a program of close medical attention, good food, and restrained exercise to "keep the patient cheerful and hopeful, temperate in all things." Financial problems caused the sanatorium to be abandoned in 1905.

Doctor Hopkins died believing his work was a failure. It was, in fact, only a temporary setback. His work captured the attention of many, and by 1908 a nationwide movement was under way for the control of one of the most common and serious illnesses known to man—efforts which historically have been commemorated during the Christmas season.

A SPECIAL PROJECT OF THE WOMAN'S AUXILIARY to the State Medical Society of Wisconsin

This holiday greeting benefits the CES Foundation. Box of 25: $5.00 (2 lines imprinted for an additional $2.50, any quantity). Orders must be received by October 15. Send orders to: Woman's Auxiliary to SMS, Box 1109, Madison, Wis. 53701. Be sure to include quantity desired and the name to be imprinted if desired.

Dennis K. Iglar, MD

. . . Watertown, recently became affiliated with Medical Associates in Watertown. He graduated from Marquette University School of Medicine and interned at Emanuel Hospital, Portland, Ore. A general practitioner, Doctor Iglar's offices are located in the Medical Associates building.

Arturo Ylagan, MD

. . . Chilton, has joined the association of general practitioners, MDs K. R. Humke* and M. H. Klein* in the Humke Clinic, Chilton. He is a graduate of Far Eastern University, Manila, The Philippines, and interned at Deaconess Hospital in Milwaukee. His residency training in internal medicine and cardiology was at Menorrah Medical Center in Kansas City, Mo.

James W. Terman, MD

. . . has joined the Gundersen Clinic and La Crosse Lutheran Hospital in the Department of Internal Medicine. Doctor Terman was born in Bloomington, Ind., where he attended the public schools and graduated from the University High School in 1957. He attended Indiana University, Bloomington, Ind., receiving his BA degree in 1961 and his MA degree in 1963. He obtained his MD degree at the Indiana University School of Medicine, Indianapolis, Ind., in 1965. Dr. Terman served his internship at the Parkland Memorial Hospital, Dallas, Tex., from 1965 to 1966. He completed his military obligation from 1966 to 1968 with the U.S. Public Health Service. He thereafter fulfilled his residency training at Vanderbilt University Hospitals, Department of Internal Medicine, Nashville, Tenn., from 1968 to 1971.

George W. Strother, MD

. . . Wisconsin Rapids, recently joined the Medical Arts Group in association with MDs Francis G. Dahlke, J. S. Mayersak, E. A. Gonzalez, and Daniel S. Mazzuchi. He received his medical degree from George Washington University, interned at the District of Columbia General Hospital, and spent two years with the United States Navy. His residency was taken at the District of Columbia General Hospital, and prior to coming to Wisconsin Rapids, he was at the Veterans Administration Hospital, Washington, D.C., concentrating on diseases of the chest.

Joseph F. Wepfer, MD*
William L. Treacy, MD*

. . . recently became the chairmen of the radiology department and internal medicine department, respectively, at St. Joseph's Hospital in Milwaukee.

Andrew L. Banyai, MD*

. . . on August 18 was made a Life Member in the Section on Internal Medicine of the Pan American Medical Association in recognition of his professional stature and contributions to Medicine. Doctor Banyai is clinical professor of medicine, emeritus, of The Medical College of Wisconsin, Milwaukee. He resides in Chicago, Ill.

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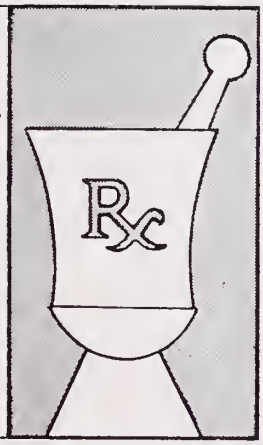

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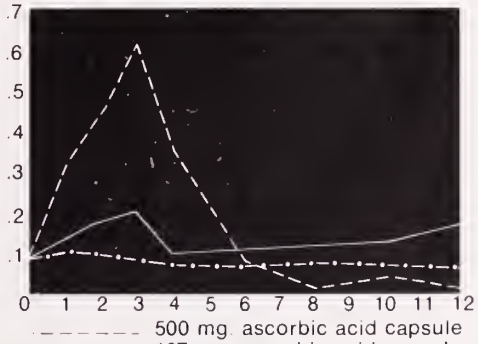

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THE NIGHT SHIFT OF DEPRESSION...

Depression is a 24-hour-a-day problem... and disturbed sleep is often its nocturnal expression. In fact, such disturbance may be a key symptom in establishing the diagnosis of depression.

WHEN THE DIAGNOSIS IS DEPRESSION

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INJECTION: 10 mg/cc

When depression is serious enough to warrant medication, ELAVIL HCl may prove extremely helpful. Unlike psychic energizers or agents that merely elevate mood, ELAVIL HCl embodies a mild antianxiety action which manifests itself even before the fundamental antidepressant activity of the drug becomes evident. Daytime drowsiness occurs in some patients, usually within the first few days of therapy.

NOTE: Not recommended during the acute recovery phase following myocardial infarction. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible. Should not be given to patients who have received an MAOI within two weeks.

Contraindications: Known hypersensitivity. Should not be given concomitantly with or within at least 14 days following the discontinuance of a monoamine oxidase inhibitor. Then initiate dosage of amitriptyline HCl cautiously with gradual increase in dosage until optimum response is achieved. Not recommended during the acute recovery phase following myocardial infarction or for patients under 12 years of age.

Warnings: May block the antihypertensive action of guanethidine or similarly acting compounds. Should be used with caution in patients with a history of seizures or urinary retention, or with narrow-angle glaucoma or increased intraocular pressure. Patients with cardiovascular disorders should be watched closely; arrhythmias, sinus tachycardia, and prolongation of the conduction time have been reported, particularly with high doses; myocardial infarction and stroke have been reported with drugs of this class. Close supervision is required for hyperthyroid patients or those receiving thyroid medication. May impair mental and/or physical abilities required for performance of hazardous tasks, such as operating machinery or driving a motor vehicle. Safe use during pregnancy and lactation has not been established; in pregnant patients, nursing mothers, or women who may become pregnant, weigh possible benefits against possible hazards to mother and child.

Precautions: When used to treat the depressive component of schizophrenia, psychotic symptoms may be aggravated; in manic-depressive psychosis, depressed patients may experience a shift toward the manic phase, and paranoid delusions, with or without associated hostility, may be exaggerated; in any of these circumstances, it may be advisable to reduce the dose of amitriptyline HCl, or to use a major tranquilizing drug, such as perphenazine, concurrently.

When given with anticholinergic agents or sympathomimetic drugs, close supervision and careful adjustment of dosages are required. May enhance the response to alcohol and the effects of barbiturates and other CNS depressants. The possibility of suicide in depressed patients remains during treatment and until significant remission occurs; this type of patient should not have easy access to large quantities of the drug. Concurrent electroshock therapy may increase the hazards of therapy; such treatment should be limited to patients for whom it is essential. Discontinue the drug several days before elective surgery if possible.

Adverse Reactions: *Note:* Included in this listing are a few adverse reactions not reported with this specific drug. However, pharmacological similarities among the tricyclic antidepressant drugs require that each reaction be considered when amitriptyline is administered.

Cardiovascular: Hypotension, hypertension, tachycardia, palpitation, myocardial infarction, arrhythmias, heart block, stroke. *CNS and Neuromuscular:* Confusional states; disturbed concentration; disorientation; delusions; hallucinations; excitement; anxiety; restlessness; insomnia; nightmares; numbness, tingling, and paresthesias of the extremities; peripheral neuropathy; incoordination; ataxia; tremors; seizures; alteration in EEG patterns; extrapyramidal symptoms. *Anticholinergic:* Dry mouth, blurred vision, disturbance of accommodation, constipation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, parotid swelling. *Endocrine:* Testicular swelling and gynecomastia in the male, breast enlargement and galactorrhea in the female, increased or decreased libido. *Other:* Dizziness, weakness, fatigue, headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, drowsiness, jaundice. *Withdrawal Symptoms:* Abrupt cessation of treatment after prolonged administration may produce nausea, headache, and malaise; these are not indicative of addiction.

How Supplied: Tablets containing 10 mg and 25 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100, 1000, and 5000; tablets containing 50 mg amitriptyline HCl, in single-unit packages of 100 and bottles of 100 and 1000; for intramuscular use, in 10-cc vials containing per cc: 10 mg amitriptyline HCl, 44 mg dextrose, and 1.5 mg methylparaben and 0.2 mg propylparaben as preservatives.

For more detailed information, consult your MSD representative or see the Direction Circular. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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Wayne J. Fencil, MD*

. . . Monroe, recently celebrated his 25th year with The Monroe Clinic. He was president of the Green County Medical Society and is presently chairman of the Monroe Clinic Executive Committee.

John H. Wishart, MD*

. . . Eau Claire, was presented a distinguished service certificate by the Wisconsin Heart Association at its 25th anniversary meeting in Milwaukee in May. He recently retired from the WHA's board of directors.

Enrique S. Manabat, Jr., MD

. . . Green Bay, recently became associated with MDs Robert J. Rose* and Richard E. Jensen,* Green Bay. Doctor Manabat graduated from the College of Medicine and Surgery, University of Santo Tomas, Philippines. He did residency work at Tarlac Provincial Hospital in the Philippines and served in the Maternity and Children's Hospital for the Manila Department of Health. A past president of the Tarlac Medical Society, he also was a member of the Philippines Medical Association and Philippine Pediatric Society. Doctor Manabat passed the educational council for foreign medical graduates and served an internship at Henrotin Hospital in Chicago before coming to Green Bay. □

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July 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for July 1971:

Nonrestricted

Anonymous	Contribution
State Medical Society Members	Voluntary contributions of 23 MDs
H. Kent Tenney, MD	Memorials: Karl Doege, MD, Harry Waisman, MD, Charles Crumpton, MD, A. J. McCarey, MD, George Moore, MD, Victor Ekblad, MD, Charles Stoops, MD, Madeline Thornton, MD, Albert Tormey, MD, James Dollard, MD, James C. Fox, MD
Earl Thayer, Dr. & Mrs. G. A. Behnke, Wisconsin Delegation to the AMA, John J. Sevenants, MD, Dr. & Mrs. John Satory, Dr. & Mrs. Paul Phillips, La Crosse Clinic Staff	Memorial: James C. Fox, MD
E. M. Dessloch, MD, C. H. Crownhart	Memorial: A. J. McCarey, MD
Earl R. Thayer	Memorial: Earl Sachse
E. J. Nordby, MD	Memorial: Otto A. Dittmer, MD
Margaret K. Pharo, Fran Ryan, LaVonne Beale & Mr. & Mrs. R. J. Anderson	Memorial: Mrs. Mina Harrington
Earl R. Thayer	Memorial: Mrs. H. E. Kasten
Dr. & Mrs. Leonard Schrank & Family	Memorial: Harold Schrank
State Medical Society	Memorials: Otto Dittmer, MD, Peter Hulick, MD

Student Loans

State Medical Society Members	Voluntary contributions of 4 MDs
Woman's Auxiliary to the State Medical Society	Contribution
H. Kent Tenney, MD	Contribution

Charitable—Disabled Physicians

State Medical Society Members	Voluntary contribution of 1 MD

Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 2 MDs

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Popp Student Loan

Albert Popp, MD	Contribution

Danforth Memorial Student Loan Fund

Mrs. Quincy Danforth	Contribution

Medical Student Summer Externship Program

R. W. Matzke, MD, Nicholas F. Damiano, MD, John C. Swan, MD, Doris M. Roob, MD, D. J. Heyman, MD, Waukesha Memorial Hospital, John L. Raschbacher, MD, Wisconsin Physicians Service, W. T. Russell, MD, Trinity Memorial Hospital, Indianhead Chapter of Wisconsin Academy of General Practice, Wisconsin Rural Rehabilitation Corp.	Contributions

Barbara Scott Maroney Memorial Fund for Research on Diabetes

H. B. Maroney, II	Memorial: Fenton Harrison

Dr. Grinde—Bell Account

Mrs. C. V. Clark, L. A. Gathh, Anna Campbell, J. Krohn, B. Shlavelski, Mrs. Alice Abraham, A. L. F. Anderson, Clarence Clapsaddle, Pat Bollig, Doug Droster, Mr. & Mrs. Lawrence Schroeder, Anonymous	Contributions

Dr. Paul R. Dyken Named Chairman MCW Neurology

Paul R. Dyken, MD* of Milwaukee has been named chairman of the Department of Neurology at the Medical College of Wisconsin (MCW). The post had been vacant for about one year.

MCW Dean Gerald A. Kerrigan, MD,* on July 1 appointed him to succeed Philip T. White, MD of Whitefish Bay, who last summer became the College's first Associate Dean for Allied Health and Continuing Education.

For the 1970–71 academic year John W. Nelson, MD* of Milwaukee, professor of neurology, served as acting chairman.

Dr. Dyken, an MCW faculty member for two years, holds associate professorships in neurology and in neurology in pediatrics. As director of pediatric neurology at MCW and Milwaukee Children's Hospital, he has been responsible for development of pediatric neurology at Children's and at Milwaukee County General Hospital. He will continue to hold these posts.

In addition he will continue as chief neurologist at Children's, a member of the neurology attending staff at County General, and a consultant in neurology at Southern Wisconsin Colony and Training Center, Union Grove.

WANTED: August Issues

The *Wisconsin Medical Journal's* supply of August issues is exhausted. There is still need for more of these copies, so if any are recoverable, please send them to the Journal office, Box 1109, Madison, Wis. 53701. And thanks! □

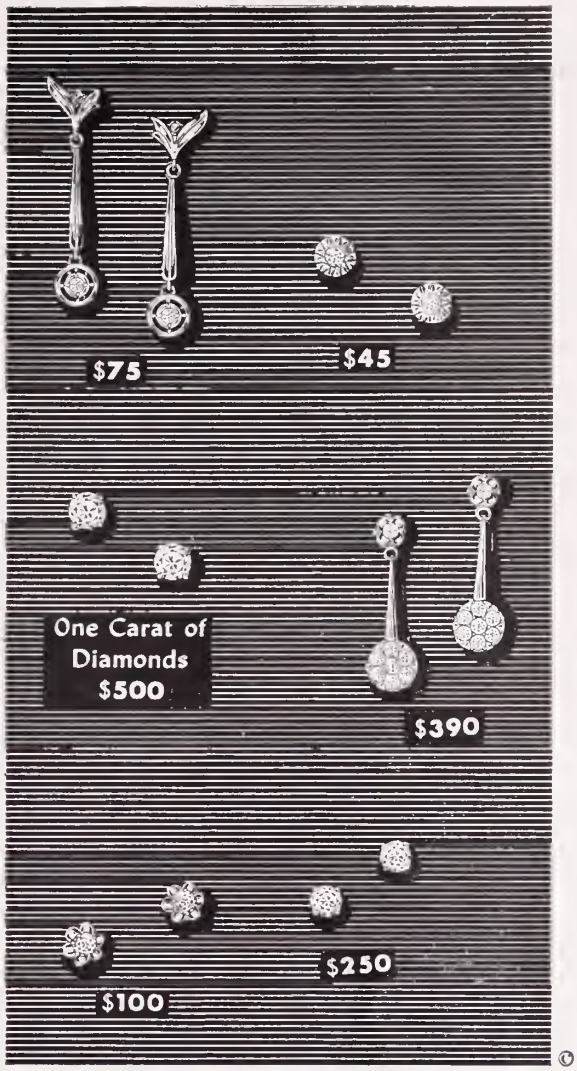
MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF AUGUST 1971

4 Board of Directors, Madison Chapter of American Management Society

16 Dane County Medical Society Insurance Advisory Committee

19 Executive Committee, SMS Council

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.



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SOCIETY RECORDS

MEMBERSHIP REPORT AS OF AUGUST 17, 1971

NEW MEMBERS

Basiliere, James L., 515 Doctors Court, Oshkosh 54901
Cravens, James G., 614 First St., Wausau 54401
Haque, Inam Ul., Winnebago State Hospital, Winnebago 54985
Kranendonk, Donald H., 630 First St., Wausau 54401
Lundstrom, J. H., Route #3, Box 29, Elkhorn 53121
Minnihan, Richard L., 1935 Grove St., #2, Oshkosh 54901
O'Connor, Paul C., 400 Ceape Ave., Oshkosh 54901
Pansch, Donald J., P. O. Box 421, Wurtsmith Air Force Base, Mich., 48753
Ping, Er Chang, Jr., 1627 Hickory St., Oshkosh 54901
Schroeder, Gerald H., 400 East Thomas St., Wausau 54401

CHANGE OF ADDRESS

Bartl, George R., 1111 Delafield Ave., Waukesha 53186
Bernhard, Gerson C., 2105 East Newport Ave., Milwaukee 53211
Brennan, John T., 2419 Wilkshire Dr., Augusta, Ga. 30904
Brodhead, Richard H., 400 Thomas, Wausau 54401
Bryan, Albert R., 1425 Portland Ave., Rochester, N. Y. 14621
del Rivero, Alfredo Cartes, 1513 East Capitol Dr., Milwaukee 53211
Cummings, Earl F., 1111 Evans St., Oshkosh 54901
Davis, Hugh L., Jr., Division of Clinical Oncology, 1300 University Ave., Madison 53706
Desch, Charles A., 223 Wisconsin Ave., Waukesha 53186
Englind, Stanley A., 21400 Jill Court, Waukesha 53186
Gregorski, Robert F., 8000 Village Oak, #A-1, San Antonio, Tex., 78233
Guten, Gary N., 5400 North Iroquois, Glendale 53217
Henderson, Robert R., 906 Edgewater Court, Madison 53715
Holder, John B., 2035 Aldergrove Dr., Allison Park, Pa. 15101
Johnson, Larry W., 643 West Pine, Lancaster 53813
Keller, Theodore A., P. O. Box 253, Brookfield 53005
Kontra, Dennis J., 467 Lombard Ave., Racine 53402
Lass, Thomas E., 7523 Bridgeman Dr., Fayetteville, N. C. 28303
Lloyd, Baldwin E., BP 31, Fort Dauphin, Madagascar
Manier, James W., 15819 Boulder Creek Dr., Minnetonka, Minn. 55343
Messanger, Michael A., 870 Central Medical Bldg., St. Paul, Minn. 55104
Norton, William I., 1604 Troy St., Wausau 54401
Schmidt, Clayton H., USAF Hospital (SG), Barksdale AFB, La. 71110
Schmidt, John P., 2729 State St., Springfield, Ill. 62704
Schumacher, John P., P. O. Box 1081, Green Bay 54305
Shinners, George M., P. O. Box 3730, Green Bay 54303
Sholtes, Clause A., Rural Route #4, Box 75, Fort Atkinson 53538
Smullen, William A., RR #1, Box 20A, Marshfield 54449
Strass, Herbert W., RR #1, Box 62B, Peshtigo 54157
Strickland, Samuel A., 2419 Fontaine Circle, Madison 53713
Syty, Joseph, 818 Frederick, Sun Prairie 53590
Theil, George B., VA Hospital, Quarters 56W, Wood 53193
Vogt, Wess R., 423 East North Point Rd., Mequon 53092
Weber, George R., 1645 East Thomas Rd., Apt. 123, Phoenix, Ariz. 85016
Weston, Eugene L., 2045 Franklin St., Denver, Colo. 80205
Wiesen, Richard L., 430 South Cherokee Dr., Brookfield 53005

DEATHS

Buckner, Homer M., Iowa County, Aug. 5, 1971
Amundson, Karl K., Dane County, Aug. 10, 1971 □

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect, discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.

Thank You, Doctor

Your continuing cooperation with the American Association of Medical Assistants has been generous. With your support our organization has achieved a membership of 14,000 medical assistants in more than 400 chapters in 45 states, District of Columbia and Puerto Rico.

Since our first organizational meeting 15 years ago, we have worked toward the primary goal of providing educational opportunities to the medical assistant in the doctor's office. In a short decade and a half the association has:

- Established and conducted a certification program as an incentive to self-education.
- Developed curricula for medical assisting programs in hundreds of junior and community colleges.
- Carried on a continuing education program for medical assistants through seminars, workshops and a professional bi-monthly journal.
- Published career materials and established a scholarship loan fund to help recruit future medical assistants.
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OBITUARIES

Peter V. Hulick, MD, La Crosse, died Apr. 7, 1971, in La Crosse.

Born on July 2, 1909, in Nanticoke, Pa., he graduated from Franklin and Marshall College, Lancaster, Pa., in 1932 and Jefferson Medical College of Philadelphia in 1936. He served an internship at Harrisburg Polyclinic Hospital (Pa.) and a residency at New Rochelle and Bellevue hospitals in New York.

Before coming to La Crosse, Doctor Hulick practiced in Nanticoke and was a member of the medical staff of Phillipsburg State Hospital; Mercy Hospital, Altoona; Indiana Hospital; and Miners Hospital, Spangler, all in Pennsylvania.

In Wisconsin he served as Chief Radiologist for St. Francis Hospital in La Crosse and St. Mary's Hospital in Sparta since 1945. He was director of the School of Radiologic Technology at St. Francis Hospital, having founded the school in 1947.

Doctor Hulick was a fellow in the American College of Radiology, a member of the American Medical Association, State Medical Society of Wisconsin, and a past secretary of the La Crosse County Medical Society. A loyal supporter of both Franklin and Marshall and Jefferson colleges, Doctor Hulick served as their Midwest representative.

Surviving are his widow, the former Helen Barno of Nanticoke, Pa., whom he married in 1935; one daughter, Patricia of Milwaukee; two sons, Navy Lt. Timothy, stationed in Norfolk, Va.; and Peter, a second-year student at Jefferson Medical College.

Charles William Harper, MD, 72, Milwaukee, died Apr. 14, 1971, in Milwaukee.

Born on Feb. 27, 1899, in Milwaukee, Doctor Harper graduated from Marquette University School of Medicine in 1924 and served his internship and residency at Milwaukee County General Hospital. Doctor Harper had been in practice in Milwaukee from 1925 until his retirement in 1969. He was chief of staff at Misericordia Hospital (now the Wisconsin Geriatric Treatment Center) from 1950–1954.

He was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Alma; a brother, Alex, Milwaukee; and three sisters, Mrs. Sarah Mathiesen, West Allis, Mrs. Joseph Taylor, Los Angeles, and Mrs. Lewis Stobbe, West Allis.

Clifford Elmer Kampine, MD, 67, Minocqua, died Apr. 23, 1971, in Minocqua.

Born on Aug. 17, 1903, in Appleton, Doctor Kampine graduated from Marquette University School of Medicine in 1933 and served his internship at Milwaukee County General Hospital. He served in the United States Army Medical Corps for two years and in 1935 opened his private practice in Marathon. He retired in 1966.

Doctor Kampine was president of the Marathon County Medical Society in 1950 and was a member of the State Medical Society of Wisconsin and American Medical Association. He was also a member of the American (and Wisconsin) Academy of General Practice and the Wisconsin Society of Obstetrics and Gynecology.

Surviving are his widow, Florence; two sons, Dr. John and Robert, of Milwaukee; and three daughters, Mrs. Paul Weninger, St. Francis; Mrs. Edward Dorzeski, Antigo; and Mrs. Kenneth Thompson, Milwaukee.

Henry F. Hoesley, MD, 85, Shullsburg, died May 1, 1971, in Shullsburg.

Born on Mar. 23, 1886, in the Primrose Township of Dane County, Doctor Hoesley graduated from Bennett Medical College, Chicago, in 1913. He had been practicing in the Shullsburg area since 1916 and retired in 1960. Doctor Hoesley was mayor of Shullsburg for 30 years and was chief medical examiner for the Lafayette County draft board.

He was a member and past president of the Lafayette County Medical Society, member of the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Julie; and a son, Robert L. of Madison.

Joseph H. May, MD, 69, Manitowoc, died May 6, 1971, in Manitowoc.

Born on Oct. 19, 1901, in St. Cloud, Minn., Doctor May graduated from Marquette University School of Medicine in 1928, and interned at Milwaukee County General Hospital. He practiced in Maribel for 40 years, retiring in 1968, and moved to Manitowoc.

Doctor May was a member of the Manitowoc County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow; two daughters, Mrs. C. S. (Judith) McConnell, Portland, Ore., and Mrs. A. W. (Jean) Slocum, Milwaukee; and a son, James, of Green Bay.

James Joseph Robb, MD, 91, Green Bay, died May 10, 1971, in Green Bay.

Born on Dec. 10, 1879, in Battersea, Ontario, Canada, Doctor Robb was a graduate of Queen's College, Kingston, Ontario, Canada, and took special training in New York Post-Graduate Hospital. He had practiced medicine in the Green Bay area for over 50 years.

Doctor Robb was a member and past president of the Brown County Medical Society, a life member of the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are his widow; two sons, James G., Richland Center, and John E. of Green Bay.

William G. Healy, MD, 60, Janesville, died May 23, 1971, in Janesville.

Born on Feb. 24, 1911, in Lisbon, Iowa, Doctor Healy graduated from the University of Wisconsin Medical School in 1943 and served his internship at Madison General Hospital. He served a surgical residency at Mercy Hospital, Canton, Ohio, following three years in the European Theater of Operations during World War II. His psychiatric residency was served at the Mental Health Institute in Independence, Iowa, and at the University of Iowa in Iowa City. He was a member of the Pember–Nuzum Clinic, Janesville, and was head of the clinic's psychiatry department.

He was a member of the Rock County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Marie; a son, James, Janesville and a daughter, Mrs. James Allen of Madison.

Bernard R. Bannen, MD, 46, Lodi, died June 8, 1971, in Madison.

Born on May 19, 1925, in La Crosse, Doctor Bannen graduated from Marquette University School of Medicine in 1954 and served his internship and residency at Milwaukee County General Hospital. He had been on the Mendota State Hospital staff in Madison since 1956. He also was a clinical instructor in the University of Wisconsin Medical School's Department of Psychiatry.

Surviving are his widow; three daughters, Kathleen, Margaret, and Colleen; and two sons, Richard and John. □

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Oct. 22: Wisconsin Orthopedic Society, Veterans Administration Hospital. Barry Friedman, MD, Cleveland, Ohio, guest speaker. Further info: James M. Huffer, MD, 1300 University Ave., University Hospitals, Madison, Wis. 53706.

Oct. 23: Fall Meeting, Wisconsin Society of Pathologists, VA Hospital, Madison. Key speaker at seminar on Pulmonary Pathology: John P. Wyatt, MD, University of Manitoba, Canada.

Oct. 23: Annual Congress, Wisconsin Association of Professions, Pioneer Inn, Oshkosh.

Oct. 30: Wisconsin Dermatological Society, Wood Veterans Administration Hospital, Milwaukee.

Nov. 11–12: *Hospital Organization for the 70's,* Midway Motor Lodge, Wausau. Info: Postgraduate Medical Education, The Wisconsin Center, 702 Langdon St., Madison 53706.

Nov. 20: Annual Meeting, Wisconsin Chapter, American College of Surgeons, St. Joseph's Hospital, Milwaukee.

1971 NEIGHBORING STATES

Nov. 1–3: Mayo Clinic Clinical Reviews, Mayo Civic Aud., Rochester, Minn. Credit of 26 hours by The American Academy of General Practice and the College of Family Physicians of Canada. Info: Postgraduate Courses, Mayo Clinic–Mayo Foundation, Rochester, Minn. 55901.

Nov. 8–10: Mayo Clinic Clinical Reviews, Mayo Civic Aud., Rochester, Minn. Credit of 26 hours by The American Academy of General Practice and the College of Family Physicians of Canada. Info: Postgraduate Courses, Mayo Clinic–Mayo Foundation, Rochester, Minn. 55901 (repeat of Nov. 1–3 postgraduate courses).

Nov. 7–11: *Surgery of the Aging Face,* Department of Otolaryngology, Abraham Lincoln School of Medicine, U. of Illinois College of Medicine, co-sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $450. Contact: M. Eugene Tardy, Jr., MD, Dept. of Otolaryn., U. of Ill. 1855 W. Taylor, Chicago, Ill. 60612.

Nov. 18–20: Mayo Clinic Conference on the Management of Respiratory Insufficiency, American College of Chest Physicians, Rochester, Minn.

Nov. 19: *Community Hospitals and the Medical Schools,* 1971 Workshop of The Institute of Medicine of Chicago, Ambassador West Hotel, Chicago. Info: The Institute of Medicine of Chicago, 332 S. Michigan Ave., Chicago, Ill. 60604. Tel: 312/663–0040.

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

Dec. 4–9: Annual Meeting, American Academy of Dermatology, Palmer House, Chicago, Ill.

1971 OTHERS

Dec. 6–9: *Pulmonary Function in Health and Disease,* eighth annual postgraduate course for physicians, Louisiana State University School of Medicine, New Orleans, La. Info: Louisiana Thoracic Society, Suite 1504, 333 St. Charles Ave., New Orleans, La. 70130. Tel: 504/523–1311.

1971 AMA

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Feb. 18–19: Annual Meeting, Wisconsin Otolaryngological Society, SMS Building, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Jan. 23–29: *Concepts of Soft Tissue Surgery,* Mercy Hospital, Pittsburgh, Pa., sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $400. Contact: John T. Dickinson, MD, DSc, G-2 MD Bldg., 1501 Locust St., Pittsburgh, Pa. 15219.

Feb. 6–11: *Rhinoplasty Workshop in Toronto,* University of Toronto Department of Post Graduate Medicine, Department of Otolaryngology, Department of Anatomy, Division of Instructional Media, sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $300, residents—$150. Contact: Mrs. Caroline Flynn, Division of Post Graduate Medicine, U. of Toronto, Toronto, Ontario, Canada.

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Feb. 27–Mar. 3: *Workshop in Advanced Rhinoplasty,* Department of Otolaryngology, Baylor University College of Medicine, Houston, Tex., sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $500. Contact: Dr. William K. Wright, Director, Suite 508 Hermann Professional Bldg., Texas Medical Center, Houston, Tex. 77025.

Feb. 28–Mar. 3: Winter meeting, American Society of Contemporary Ophthalmology, Diplomat Hotel, Hollywood, Fla. Info: John G. Bellows, MD, Secretary, 30 North Michigan Ave., Chicago, Ill. 60602; tel. 312/236–4673.

Mar. 13–16: *Maxillofacial Trauma,* Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center, Cincinnati, Ohio, sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Tuition: $400. Registrar: Miss Debby Adkins, Office of CONMED, Room 114, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

April 21: Symposium on Infectious Diseases, American Academy of General Practice, Battenfeld Auditorium, Kansas City, Kan.

Apr. 23–29: Ninth Interamerican Congress of Cardiology, San Francisco, Calif.

May 12–13: Clinical–Professional Meeting, American College of Legal Medicine, Americana Hotel, Miami Beach, Fla. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

Sept. 25–28: Annual scientific assembly, American Academy of General Practice, New York Coliseum, New York, N.Y.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Biltmore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New York N.Y. 10017.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1974 INTERNATIONAL

Oct. 20–26: XIth International Cancer Congress, Florence, Italy.

For listing of other meetings see the **Journal of the American Medical Association.**

SMS In-Depth Teaching Programs—Madison

The 1971–1972 In-Depth Teaching Programs sponsored by the State Medical Society's Charitable, Educational and Scientific Foundation have been scheduled for five one-day sessions: Wednesday, Nov. 17, and Thursday, Dec. 9, 1971; and Wednesday, Jan. 19, Thursday, Feb. 17, and Wednesday, Mar. 15, 1972, at St. Mary's Hospital Medical Center in Madison.

Registration starts at 9 am with the program running from 10 am to 3 pm, with lunch available. Physicians will choose one topic out of a list of 15 for each day they plan to attend. The program director will then assign the physician to the day in which his topic will be presented. These presentations will be conducted during the morning period with a lecture series in the afternoon.

The 15 topics from which the physician can select no more than five (one topic per day) are as follows:

1. Obstetrical Care for High Risk Pregnancies, by E. L. Roley, MD

2. Day to Day Management of Emotional Problems, by R. L. Beilman, MD and Stanley Miezio, MD

3. Management of the Adolescent Crisis, by Robert B. Shapiro, MD and Conrad L. Andringa, MD

4. Coronary Crisis, by Richard J. Hendricks, MD

5. Pediatric Problems, by Thomas V. Geppert, MD

6. Common Neonatal Problems, by Stanley N. Graven, MD, Richard D. Zachman, MD and William Stuart, MD

7. Trauma Problems in the Hospital Emergency Room, by E. E. Skroch, MD

8. Orthopedics—Simple Fractures, by James E. Miller, MD, et al

9. Cardiology, by William Rock, MD, Robert J. Corliss, MD and Marion K. Ledbetter, MD

10. Sneezes, Wheezes, Itches, Etc., by John J. Ouellette, MD and William L. Kopp, MD.

11. Pulmonary Disease, by Paul O. Simenstad, MD and James W. Rose, MD

12. Antibiotics Can't Cure Everything, by William Scheckler, MD and Donn J. D'Alessio, MD

13. Medical Ophthalmology, by John W. Doty, MD

14. Dermatology, by Hubert V. Moss, MD and Thomas S. Kemp, MD

15. Arthritis—Informal Discussion, by Walter R. Sundstrom, MD, Mark N. Mueller, MD and Robert A. Bonebrake, MD

Two lectures with discussion periods will be conducted by members of the UW Medical Faculty from 1:30 to 3 pm. These are as follows:

WEDNESDAY, NOV. 17, 1971: "The First 60 Minutes After Myocardial Infarction," by Richard Wasserburger, MD, professor of medicine, VA Hospital, Madison; and "The Next 47 Hours," by Neville Bittar, MD, assistant professor of medicine, University of Wisconsin (UW) Medical School Faculty, Madison.

THURSDAY, DEC. 9, 1971: "Management of Angina Pectoris," by George G. Rowe, MD, professor of medicine, UW Medical School Faculty, Madison; and "When and Whom to Refer for Coronary Angiography," by James H. Thomsen, MD, assistant professor of medicine, VA Hospital, Madison.

WEDNESDAY, JAN. 9, 1972: "The First 60 Minutes After Pulmonary Embolus," by George E. Magnin, MD, associate clinical professor of medicine, UW Medical School Faculty, Madison; and "Selection and Plan for Anticoagulant Therapy," by Donald R. Korst, MD, associate professor of medicine, UW Medical School Faculty, Madison.

THURSDAY, FEB. 17, 1972; "Immediate Care of Acute Stroke," by Francis M. Forster, MD, professor of neurology, UW Medical School Faculty, Madison; and "Current Management of Diabetic Keto-acidosis and Coma," by Edgar S. Gordon, MD, professor of medicine, UW Medical School Faculty, Madison.

WEDNESDAY, MAR. 15, 1972: "Current Management of Rh-ve Pregnant Patient Before and After Delivery," by J. Morton Schneider, MD, assistant professor of gynecology and obstetrics, UW Medical School Faculty, Madison; "Current Management of the Newborn Who Becomes Jaundiced in the First 24 Hours," by Patricia J. Joo, MD, assistant clinical professor of pediatrics, UW Medical School Faculty, Madison; and "Dx and Rx of Salicylate Poisoning," by William E. Segar, MD, professor of pediatrics, UW Medical School Faculty, Madison.

Five hours of American Academy of Family Physicians credit will be earned for each program attended. Registration must be made by October 20 with S. E. Sivertson, MD, State Medical Society of Wisconsin, P. O. Box 1109, Madison, Wisconsin 53701.

Registration fee: $8 per session or $30 for all five. Coffee and lunch are included.

These In-Depth Teaching Programs are being presented by the CES Foundation in cooperation with the University of Wisconsin Medical School Faculty, St. Marys Hospital Medical Center, Madison Chapter of the Wisconsin Academy of Family Physicians, and the Postgraduate Program of Merck, Sharp and Dohme.

Hospital Organization Conference—Wausau

"Hospital Organization for the 70's" will be discussed by hospital trustees and governing boards, hospital administrators, chiefs of medical staffs, and other interested health professionals at a conference Nov. 11 and 12 at the Midway Motor Lodge in Wausau.

The conference will provide an opportunity to delve into some of the critical issues to be faced in the delivery of health care during this decade. It is structured to allow for intense discussion of these issues with nationally recognized speakers and Wisconsin counterparts.

The program faculty includes: William L. Blockstein, PhD, chairman, Health Sciences Unit, University Extension, University of Wisconsin (UW), Madison; Clement R. Brown, MD, director of medical education, Chestnut Hill Hospital, Philadelphia, Pa.; T. A. Duckworth, senior vice-president and secretary, Employers Insurance of Wausau, Wausau;

Benjamin H. Glover, MD, associate professor of psychiatry, UW, Madison; Gordon N. Johnsen, MHA, administrator, Madison General Hospital, Madison; James R. Kimmey, MD, executive director, American Public Health Association, New York, N.Y.; Matthew F. McNulty, Jr., ScD, vice-president for medical center affairs and professor of community medicine and international health, Georgetown University, Washington, D.C.;

Thomas C. Meyer, MD, chairman, Department of Postgraduate Medical Education, and associate dean, UW Medical School, Madison; John H. Renner, MD, associate clinical professor of postgraduate medicine, and director of family practice program, UW Medical School, and St. Mary's Hospital Medical Center, Madison;

George Shapiro, MD, professor, Department of Speech and Communication, University of Minnesota, Minneapolis, Minn.; and Warren Von Ehren, MHA, executive director, Wisconsin Hospital Association, Madison.

Subjects to be covered include: Dilemma of Teaching Hospitals, The Evolving Role of the Hospital Trustee, Approaches to Effective Medical Staff Management, The Problem-Oriented Medical Record, The By-cycle Concept: Patient Care Diagnosis Before Educational Therapy, and Current and Future Issues in the Delivery of Health Care.

The two-day conference is sponsored by the Madison Hospitals Medical Staffs and Hospital Administrators Council in cooperation with the University of Wisconsin Health Sciences Center and University Extension Department of Postgraduate Medicine.

Program chairmen are: George C. Hank, MD, medical director, St. Mary's Hospital Medical Center, assistant clinical professor of gynecology and obstetrics, UW Center for Health Sciences, and chairman of the Madison Council of Hospital Administrators and Chiefs of Medical Staffs, Madison; and Thomas C. Meyer, MD, chairman, Department of Postgraduate Medical Education, and associate dean, UW Medical School, Madison.

Registration fee of $60, or $165 team fee, covers tuition, materials, two coffee breaks, one luncheon and the dinner. Registration can be made with the Coordinator, Postgraduate Medical Education, The Wisconsin Center, 702 Langdon St., Madison, Wis. 53706.

Mid-America Hospital Medical Staff Conference

The Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area are cosponsoring a Mid-America Hospital Medical Staff Conference during the week of June 19–23, 1972.

The conference is designed for physicians, hospital administrators, and trustees. It is similar to the Conference conducted annually at Estes Park, Colorado, under the auspices of the University of Colorado School of Medicine. The originator and director of the Estes Park Program, C. Wesley Eisele, MD, will conduct the Mid-America Conference next June.

The Conference will be held at the Abbey in Fontana, Wisconsin. Program and registration forms will be mailed soon to hospital medical staff presidents.

Interstate Scientific Assembly—New Orleans

The 56th Annual Scientific Assembly of the Interstate Postgraduate Medical Association will be held in New Orleans, La., Nov. 15–19, one extra day from the traditional Assembly program. The extra day provides a special presentation by the Arthritis Foundation with nationally known speakers, and at no increase in fee.

This Assembly is one of the few meetings where closed circuit color TV will be provided, through auspices of Roche Laboratories, with the teaching correlated with patient presentations at Charity Hospital, New Orleans.

Two Wisconsin physicians are on the program: Joseph M. Benforado, MD and Edgar S. Gordon, MD of Madison. Dr. Benforado will speak on Monday, Nov. 15, on "The Judicious Prescribing of 'Uppers and Downers' (Amphetamines and Sedatives). Also on Monday, Nov. 15, Dr. Gordon will speak on "The Importance of Prostaglandins in Clinical Medicine."

The banquet speaker Wednesday, Nov. 17, will be Beverley T. Mead, MD of Omaha who will talk on "The Battle of the Sexes."

The program is acceptable for 23½ prescribed and 8½ elective hours by the AAGP. It also is accredited by the AMA Council on Medical Education and is acceptable for credit toward the Physicians Recognition Award of the AMA.

Advance registration by Nov. 13 is $25; thereafter, $35. Info: Roy T. Ragatz, IPMA, P. O. Box 5445, Madison, Wis. 53705. □

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WISCONSIN MEDICAL JOURNAL
Vol. 70, No. 10 OCTOBER 1971

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

SMS Calls Special Session of House of Delegates

(3) No health care institution receiving governmental funds for the construction of facilities or the reimbursement for services shall commence the erection, building, alteration, reconstruction, improvement, extension or modification of facilities the cost of which exceeds $100,000 and which is not properly chargeable as an expense of operation and maintenance under generally accepted accounting principles or embark upon a program of expansion of the scope or type of services rendered, before it receives a certificate of need under this section.

THE VITAL PORTION OF THE CERTIFICATE OF NEED BILL is shown above. It is taken from Substitute Amendment 1 to Assembly Bill 1104. At a public hearing this version of the bill was supported by the Wisconsin Hospital Association and the Wisconsin Council of Homes for the Aging.

Certificate of Need Is Proposed for Physician Offices and Services

Certificate of need legislation was first introduced into the Wisconsin Legislature on June 24, 1971, as Assembly Bill 1104. It was introduced by the Committee on Health and Social Services of the Assembly at the request of the Wisconsin Department of Health and Social Services (DHSS).

This bill, following a form fairly typical to similar bills in some 15 other states, required licensed health care institutions (such as hospitals or nursing homes) to obtain a certificate of need before they could erect a new building or alter, reconstruct, improve or modify existing facilities. In addition, a similar certificate of need would be required if those facilities wished to alter any services related thereto.

The State Medical Society, following the direction of the House of Delegates in May, took the position that physicians and county medical societies should actively participate in comprehensive health planning but that the concept of certificate of need was not in the best interest of patient care. It expressly objected to the inclusion of the phrase "services related thereto" since the Society believes that such a phrase may be administratively interpreted to cover physicians and their services.

The Society was informed that there was "no intention" to cover physicians or their services but no clarifying language was offered.

Under AB 1104 the required certificate would be granted only after review and recommendation by the areawide comprehensive health planning agency and the DHSS.

When the bill came to public hearing on September 17, the Wisconsin Hospital Association endorsed the concept but opposed the

continued on page 30a

TO MEET AT SOCIETY OFFICES OCTOBER 23

The State Medical Society has reacted to proposed legislation on "certificate of need" and employment of physicians by hospitals with a call for a special session of its House of Delegates at the Society headquarters in Madison on October 23.

The decision to call the delegates to Madison was made by unanimous vote of the Council (board of directors) almost immediately after receiving information on the impending introduction of a bill to permit employment of physicians on salary by hospitals and health maintenance organizations. This would require repeal or amendment of the state's fee splitting statutes which, like similar laws in other states, prohibit this practice.

The Council has also expressed concern with new proposals for "certificate of need" which give the Department of Health and Social Services the final say as to when, where and if physicians' services can be provided or medical facilities built. The Council believes this creates a state-controlled franchising of health care.

The special session will consider "health care legislation" including but not necessarily limited to these two bills. The Council requested that all members of the Society be provided with basic information concerning this legislation and asked them to contact their delegates or county society officers so that the House will be able to act on an informed basis.

Bill Would OK Salaried Physicians in Hospitals

Acting at the request of Governor Lucey, Milwaukee Representative Joseph Czerwinski has introduced Assembly Bill 1391 to permit the employment of physicians on salary by hospitals.

The present fee splitting law and the changes proposed by the bill are shown on the opposite page.

Addressing the Legislature on May 18, 1971, Governor Lucey said: "I will introduce legislation to allow salaried physicians in hospitals to participate in health maintenance organizations. This will be a beginning in moving away from the exclusive fee-for-service basis of health care. This legislation is an important first step in helping to eliminate existing health cost problems."

Representative Czerwinski in contact with the State Medical Society headquarters said he would seek to bring the bill to an early hearing. While recognizing the legislation would carry out the intent expressed by the Governor, Representative Czerwinski also was interested in a more specific goal: to free hospitals to employ salaried physicians so that they might provide 24 hour emergency room service. Representative Czerwinski believes that lack of ability to employ physicians is a major barrier to making these facilities available, especially in urban areas.

Wisconsin is one of the few states which has specific prohibition against hospital employment of physicians on salary, but most states have fee splitting statutes which prohibit the corporate practice of medicine—and their courts have repeatedly held that physicians cannot be hired by a corporation (including a hospital) which in turn sells their services.

The drive to employ physicians in hospitals has already received preliminary endorsement from a subcommittee on financing of the Governor's Health Care Task Force. In a recent report the subcommittee listed as its number one "preliminary issue" the proposition that "legislation is needed to permit payment of salaries to MDs."

Salaried physicians are regarded by many as essential to the development of hospital centered health care of the future. At the September 12 dedication of the Wisconsin Hospital Association's new building in Madison, David Carley, chairman of the Governor's Health Planning and Policy Task Force, challenged hospitals to take the leadership in health care delivery. "Unless hospitals become the operational centers for better health care for all citizens," Carley said, "they will be isolated and bypassed."

The current effort to employ physicians on salary in hospitals is reminiscent of the 1957–59 controversy between the Wisconsin Hospital Association and the State Medical Society on the same issue. The Wisconsin Legislature first enacted a law to prohibit fee splitting by physicians in 1913. When doubt was raised as to whether this prohibited fee splitting between physicians and hospitals, the Legislature in 1915 promptly amended the law to clearly prohibit fee splitting between them.

In 1957, the Wisconsin Hospital Association sought to legalize contracts between hospitals and physicians under which the physician could receive either a salary (hired employee) or a division of the net of his department (fee splitting). In the ensuing controversy it became clear that hospitals sought to engage radiologists, pathologists, anesthesiologists and physiatrists, and retail their services as the hospital administrators saw fit.

The State Medical Society felt that these practices would increase costs to the patient, restrict the services of these specialties, and deprive many people, especially in rural areas, of adequate care. After long negotiation the Society and the Wisconsin Hospital Association agreed on, and the Legislature in 1959 enacted into law, a revised fee splitting statute which prohibits fee splitting and salaried physicians in hospitals, but authorizes certain types of contractual relationships between hospitals and physicians including a single hospital bill for services of certain specialists providing it indicates the source of the medical charges as distinguished from hospital charges.

In an interpretation of the 1959 fee splitting law the medical society indicated that salaried physicians were not violating the law if they were employed in government hospitals or teaching hospitals attached to a medical school, "provided that neither type of institution bills the patient for the professional services of any physician."

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MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

HEW Rules Under Medicare Clarified on Physician Visits to Nursing Homes

There has been considerable confusion with respect to the existence of the following HEW rules:

(a) The physician to visit a nursing home patient once a month.

(b) In the absence of a "regular physician" for a nursing home patient, to require an annual physical examination for such patient.

WPS, the administrator for Medicare in Wisconsin outside Milwaukee County, has issued the following statement in an effort to clarify the situation.

"These two rules were originally established by HEW as requirements for Medicare-Part B patients in a *Certified Extended Care Facility*. The Medicare benefit period for ECF patients is limited to 100 days for each spell of illness.

"In 1970, HEW adopted the same requirements for all Medicaid (Title 19) patients who are in *Skilled Nursing Facilities* or *Nursing Homes*.

"The nursing homes are thereby required to demand at least once a month visits by physicians to their patients as a condition of participation for the facility under these government programs."

Employment of Physicians

Proposed changes in fee splitting law—Assembly Bill 1391, introduced October 7 by Representative Czerwinski at the request of Governor Lucey, proposes to permit employment of physicians by changing the present Wisconsin statutes as shown on this page.

448.23 Fee splitting between physicians and others. (1) Separate billing required. Any physician who renders any medical or surgical service or assistance whatever, or gives any medical, surgical or any similar advice or assistance whatever to any patient, physician, corporation, or to any other institution or organization of any kind, including a hospital, for which a charge is made to such patient receiving such service, advice or assistance, shall render an individual statement or account of his charges therefor directly to such patient, distinct and separate from any statement or account by any physician or other person, who has rendered or who may render any medical, surgical or any similar service whatever, or who has given or may give any medical, surgical or similar advice or assistance to such patient, physician, corporation, or to any other institution or organization of any kind, including a hospital.

(2) Physician partnerships permitted. Notwithstanding any other provision in this section, it is lawful for 2 or more physicians, who have entered into a bona fide partnership for the practice of medicine, to render a single bill for such services in the name of such partnership.

(3) Contract exceptions; terms. ~~Notwithstanding any other provision in~~ this section, when a ~~hospital~~ and its medical staff considers that it is in the public interest, ~~it~~ is lawful for a physician to contract with a hospital [~~to provide consultation services for attending physicians~~] as herein provided. [~~Any~~] treatment by such a consultant shall be in his capacity as a private practitioner; his relationship to the patient shall be governed accordingly: and such treatment shall be rendered only at the request of the attending physician, except that a physician specializing in pathology, physical medicine or radiology may include the treatment of referred cases in his contract with a hospital. [~~Such contract~~] shall:

1. ~~(a)~~ Require [~~such~~] the physician to be a member of or acceptable to the medical staff of such hospital.

~~(b) Not create the relationship between hospital and physician or employer-employe, excepting only that any contract for deferred compensation, including but not limited to an annuity, in force on January 1, 1961, shall not be modified or abrogated by the force of any provision of this subsection.~~

2. ~~(c)~~ Permit [~~such~~] a physician contracted with as a consultant to exercise his professional judgment without supervision or interference by such hospital.

3. ~~(d)~~ Establish the remuneration of the physician [~~on any basis other than a salary.~~]

(c) ~~(e)~~ If agreeable to the contracting parties, such hospitals are authorized to charge the patient for services rendered by such physicians, but the statement to the patient shall indicate that the services of such physicians, who shall be designated by name, are included in the departmental charges.

(4) Definitions. As used in this section;

(a) "Hospital" means an institution providing 24-hour continuous service to patients confined therein which is primarily engaged in providing facilities for diagnostic and therapeutic services for the surgical and medical diagnosis, treatment and care, of injured or sick persons, by or under the supervision of a professional staff of physicians and surgeons, and which is not primarily a place of rest for the aged, for drug addicts, for alcoholics, or a nursing home. Such hospitals may charge patients directly for the services of their employe nurses, nonphysician anesthetists, and for medical assistants, other than physicians or dentists, and may engage on a salary basis interns and residents who are participating in an accredited training program under the supervision of the medical staff, and persons with a temporary educational certificate issued under s. 448.04.

(a) When a physician is contracted with as a consultant,

(b) Contracts under this subsection

To be repealed.

Conflicting Views Aired on Certificate of Need

The question of whether "certificate of need" legislation is desirable is being widely debated across the country. With the passage and implementation of Public Law 89–749 areawide comprehensive health planning began to develop rapidly throughout the nation. With it came efforts to put "teeth" into areawide planning activities.

When the Wisconsin Board of Health and Social Services considered the certificate of need proposal earlier this year, it was told that "the purpose of the legislation is to conserve the limited health care resources of manpower and facilities in the interest of providing quality health care to all citizens, to minimize duplication, to encourage development of alternative methods of delivering health care, and maximize the effectiveness of expenditures made for health care which by 1980 will reach an estimated $189 billion in the U. S."

At least three of the four areawide comprehensive health planning agencies (Madison, Green Bay, and La Crosse) expressed support for the legislation. The State Council on Health, which advises the Division on Health, also approved the idea of a certificate of need law.

Proponents of the certificate of need approach consider such legislation necessary to "provide health care institutions at the local level an opportunity to review proposed programs with representatives from the area to be served." They say that "overall community needs would be considered rather than separate institutional needs without regard to other institutions providing similar services in the community."

They point out that existing federal legislation would require federally aided projects to be submitted to areawide health planning review before funding. Although such projects are few, state legislation would bring all government assisted projects into the process of organized planning.

Supporters also feel that certificate of need will "promote optimum utilization of existing facilities and health manpower by avoiding duplication of entire facilities, questionable expansions, costly equipment and similar multiple services."

Opponents believe that certificate of need legislation would limit competition and restrict the free enterprise system. They feel that such controls are "oppressive and tend to destroy voluntary planning." Others add that "reduced competition without adequate controls would tend to increase the use of poor quality institutions." Some feel certificate of need would tend to favor large, well medically-supported communities to the detriment of smaller communities. Many persons interested in helping poverty stricken areas contend the bill would be an effective barrier to innovation being attempted by consumer groups, physicians, and others.

The Council of the State Medical Society at a recent meeting pointed out there was no need to develop state implementing laws at this time since action on an important federal proposal is pending in Congress under which there are dollar limitations affecting the facilities for which a certificate of need is required.

Society Has Book on Track and Field Sports

As the new school year gets under way, physicians will be treating more injuries resulting from competitive sports. MDs who frequently see such cases may be interested in a State Medical Society book which deals with special physiological and medical considerations of track and field sports.

The book contains the results of a two-day Track and Field Institute held at the University of Wisconsin in 1966. Physicians and coaches from across the country reported on the mechanisms of running, and on training for running and field events. The institute was coordinated by Allan J. Ryan, MD, University of Wisconsin associate professor of physical education and rehabilitation medicine and athletic teams physician.

The book sells for $5 and is available from the Society's Charitable, Educational and Scientific Foundation, Box 1109, Madison, Wis. 53701.

New Rules on Paying for Nursing Home Visits: Medicare-Part B

Since Jan. 1, 1971, WPS has been issuing Medicare-Part B payments for nursing home visits according to the following rules set forth in a HEW directive:

(1) Payment will be made for only one visit per month to any one nursing home patient unless an acute illness is substantiated by explanatory information on the claim form.

(2) Payment for a single patient visit in a nursing home will be made at a rate not to exceed the customary and prevailing charge for a routine follow-up *house* call.

(3) Payment for each patient seen on a multiple-patient visit to a nursing home will be made at a rate not to exceed the customary and prevailing charge for a routine follow-up *office* visit.

(4) Charges in excess of the customary and prevailing charges for the visits outlined above will be allowed only when explanatory information on the claim form identifies the need for more intensive or more prolonged patient care.

In the absence of a clear indication to the contrary on the claim form, WPS, as Part B carrier, is required by HEW to assume that a visit to a patient in a nursing home was a routine multiple-patient situation and to make payment on that basis. HEW also requires that physicians be informed that when reporting nursing home visits where only one patient is seen, they must report specifically on the claim form a statement such as "ONLY PATIENT SEEN" to assure avoidance of misunderstanding.

WPS has emphasized the point that HEW requires the insurance carrier to establish and use separate codes for identifying visits to nursing homes so that the records distinguish between visits where one patient has been seen and visits where two or more patients have been seen.

Pros and Cons Concerning Employment of Physicians

The merits of the hospital salaried physician have been debated in Wisconsin for more than half a century. Most states have fee splitting statutes which, among other things, prohibit hospitals from engaging a physician and retailing his services as the administrator sees fit. Some of the same states as well as others prohibit corporate practice of medicine (hired employee). Regardless of the form of the statutes, in most states their courts have commonly held that physicians cannot be hired by a corporation (including a hospital) which in turn sells their services. The chief concern is the direct responsibility of the physician to his patient—and what this means to the patient's health.

Proponents of salaried physicians in hospitals contend that such arrangements would permit hospitals to stabilize costs (salaries), better predict overhead, and reduce administrative costs. They argue that in emergency rooms, for example, salaried physicians would put the department on a "break even" or "profit making" basis as is typical of other departments such as radiology and pathology. These profits are in turn used to offset losses in other areas of the hospital such as room and board and miscellaneous services.

Supporters of this legislation believe salaried arrangements would permit more effective use of the physician's professional time, and give them predictable income with assurance of regular hours, time off and fringe benefits. They believe it would encourage the more rapid development of hospital centered health maintenance organizations and enable the medical staff to have greater control of physician members. They deny that the physician's professional independence would be affected.

Opponents of salaried physicians in hospitals argue that employment of physicians will make them responsible to the hospital rather than the patient, and reduce their freedom of professional decision via policies and resources controlled by hospital administration. They fear that large institutions in metropolitan areas would use their greater resources to attract employment of large numbers of physicians, particularly in certain specialties, thus causing further maldistribution of physicians and depriving smaller communities of the few physicians they now have. They point out that freedom of choice by the patient would be restricted, and physicians may be limited in their choice of location to practice.

On the economic side opponents believe that salaried use of physicians would conceal the realities of hospital costs and postpone their recognition or solution. The effect would be to increase rather than decrease overall costs of health care, they say.

Opponents also contend that it is not necessary for hospitals to salary physicians to develop health maintenance organizations in Wisconsin. Present statutes permit consumer groups to develop cooperative health services (health maintenance organizations) and to arrange for medical services on a salary. The essential difference in this situation is that the physician is responsible directly to the consumers, whereas employment by hospitals interposes a third party between the physician and the ultimate consumer.

Background Brief

Historically, *corporate practice of medicine* and law and other professions is forbidden in Wisconsin as in many other states. Reason: only an individual physician can be licensed to practice medicine. The obligation that a physician has to his patient is his alone. If a physician becomes an employee of a corporation which in turn sells his services, the physician has undertaken responsibilities which may be irreconcilable and which may not be in the best interest of the patient. In other words, what is best for the patient may or may not be for the best interest of the corporation which has hired the physician. Quality of care to the patient may suffer seriously.

Historically, also, *fee splitting* is almost universally forbidden by law, and in addition it is regarded as highly unethical by the profession. Reason: fee splitting, particularly when it is hidden, leads to ghost surgery, unnecessary operations, and increased costs to the patient.

'72 Annual Meeting Dates Firmly Set for May 9–11

The State Medical Society's 1972 Annual Meeting has been firmly set for May 9–11 in Milwaukee. It will not, however, be using the facilities of the Milwaukee Auditorium as originally scheduled. The Hotel Sheraton–Schroeder will again be used for exhibits, scientific programs, and art show.

CERTIFICATE OF NEED

continued from page 27

original bill and offered instead its support for a much broader version known as Substitute Amendment 1 to AB 1104. The substitute (excerpt shown on page 27) goes far beyond any reported certificate of need legislation anywhere else in the country.

This bill requires that every "health care institution" (defined as any facility whose primary purpose is to provide health care whether licensed or not) must have a certificate of need before expanding the scope or type of services rendered. Furthermore, it provides that such facilities cannot be built, expanded or modified without a certificate of need if the cost is to be $100,000 or more. It also requires notice to the areawide comprehensive health planning agency before any consultant (architectural, professional or fund raising) is engaged for planning such expansion of facilities or services. Violations are subject to injunction or fine. The certificate of need may be issued either as applied for or as modified by the DHSS.

It is clear from this bill that physician office facilities and services are covered by the new bill.

In the September public hearing the Society expressed the belief that this proposal could very well deprive communities of their autonomy in assessing needs and assigning priorities of planning. It was pointed out that the proposal would tend to stifle innovation by encouraging communities to design plans for the purpose of getting them approved rather than doing planning for the purpose of meeting real needs.

Keeping the Issues in Focus

Society Secretary Earl R. Thayer presented the following remarks to a special meeting of the Council on October 2, called to discuss certificate of need and employment of physicians.

You are here this afternoon to consider two very significant pieces of legislation. Both involve precepts of health care and patient–physician relationships which have been of long standing and basic ethical consideration to the medical profession in Wisconsin. One of these precepts —fee splitting and corporate practice—has been a matter of law for nearly 60 years.

Both are increasingly involved nationwide in discussions of the role of the medical profession to health care in a changing society. Both have been authored by the same representative in the State Assembly—Representative Czerwinski of Milwaukee, chairman of the Assembly committee on health and social services. Both have the endorsement of the Wisconsin Hospital Association, and both have a potentially common result—abridgement of physician independence to the detriment of patient care—and further centralization of health care delivery and control in the hospital.

The State Medical Society on many occasions has stated its sincere conviction that in the complex relationship between providers, facilities, government and the consumer, the sole controlling motivation must be the patient interest. This is a premise with which there can be no compromise.

At the same time the means by which the patient interest is better served is undergoing challenge—challenge brought on by changing public attitudes, changing economic circumstances, changing values of society. This debate is being conducted on a number of premises, each of which will influence the decisions on the two proposals you are considering today.

One premise is that change is not only necessary and inevitable, but that it must be speeded up *right now*. It is a premise that any system of health care would be better than the one we have, that almost any change is for the better. It is a premise that says experiment—innovate —if you haven't tried it, try it.

A second premise is the public's great concern with costs and particularly the costs of health care. As expressed by the average family with major or even routine health care problems, the concern is an honest and genuine one. The demand is for relief. Little matter that these costs are the result of expanding sophistication in medical and health care techniques—the result of the demands of public for more and better service arising out of their own understanding of good health—the result of general inflation in wages and prices, especially in hospitals. The demand is for relief and the political reaction is a natural one—the promise of relief through legislation.

A third premise is that segments of our society experience special problems with health care and thus special measures are required to ease their burden. For the poor in the city ghetto it is a lack of availability of service—an inability to get into the system. Or lack of funds, or transportation. For the rural poor, even though they know where to go, it may be cost or long distances to physicians. For the Spanish speaking there are language and educational barriers. For each and for all, the premise is that some special remedy is needed.

A fourth premise is that the public is today increasingly more able to judge the relative quality and quantity of care it receives or has available to it. The educational processes of the past quarter century—in which you as practicing physicians and your Society have actively participated with literally tons of literature, thousands of hours of special classes and meetings, including the Work Week of Health, the educational radio programs of Doctor Tenney, and the radio and TV shows of the AMA and the AAGP, such as Marcus Welby, the publicity to professional liability suits, and the increased sophistication of your own profession as well as the public—all have created a population which to a large degree can fairly readily and accurately perceive and assess the general level of health care.

These are the premises on which the public and the legislator are reacting today. They substantially influence the climate in which these two legislative proposals will be considered in the coming weeks, and if action is not completed in this session, certainly in 1972.

It is in this context that I trust the profession will consider these bills and always with one overriding concern—the patient interest.

Bills Before Assembly Committee

Both the certificate of need and employment of physicians bills are pending before the Assembly Committee on Health and Social Services. Its members are:

The Hon. Joseph Czerwinski, Chm., (D) —1230 South 34th Street, Milwaukee 53211

The Hon. William Rogers, Vice Chm., (D)—1800 Peters Road, Kaukauna 54130

The Hon. Harvey Dueholm, (D)—Luck 54853

The Hon. Harout O. Sanasarian, (D)—1111 North Astor Street, Milwaukee 53202

The Hon. Michael P. Early, (D)—1052 South Fork Drive, River Falls 54022

The Hon. Marjorie M. Miller, (D)—1937 Arlington Place, Madison 53705

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The Hon. Kenneth M. Schricker, (R)—Route 2, Spooner 54801

Physicians are urged to contact not only members of this committee but their own Assemblymen and Senators to express their personal views. These are basic but very complex issues. If at all possible, it would be best for you to discuss them with your legislative representatives in person.

Members are encouraged to contact delegates and alternates of their respective county societies prior to the House of Delegates meeting on October 23.

Delegates and Alternates—1971

STATE MEDICAL SOCIETY OF WISCONSIN

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	W. C. Rattan	R. G. Burnett
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PUBLIC HEALTH	G. E. Howe	G. H. Handy
RADIOLOGY	A. B. Fidler	Vacancy
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UROLOGY	J. W. Kearns	C. L. Weisenthal

THE STATE MEDICAL SOCIETY'S PRESIDENT, Dr. George A. Behnke of Kaukauna is shown making the presentation of a photo mural recognizing the Wisconsin Hospital Association's 50th Anniversary.

Photo-Mural Presented for New Hospital Association Quarters

A photo-mural depicting a half century of hospital and health care progress in Wisconsin was the State Medical Society's gift to the Wisconsin Hospital Association (WHA) at dedication of the new Association headquarters. George A. Behnke, MD, State Medical Society president, made the presentation at the September 12 ceremony.

In a letter presented with the mural, Dr. Behnke noted that Wisconsin has "a level of hospital service which is the envy of the nation." He said "we are proud, as a Society and as members of the medical staffs of the hospitals in Wisconsin, to have been a part of your Association's growth and activities over the past 50 years."

The photo-mural shows modern and historic hospital buildings and officers of WHA since its founding in 1920. The mural will be displayed in the Association's new $970,000 headquarters on Madison's far west side.

Transportation Problems in Health Care Receive Task Force Attention

Transportation for both emergency and non-emergencqy health care has been cited as an issue of "highest priority" by Governor Lucey's Health Task Force. At its September 13 meeting the Task Force adopted a resolution asking the Governor to appoint a special study group on the subject from among executive agencies. This special group is to report back to the Task Force in one month on problems and possible solutions.

Hartland Physicians Conduct Own Survey to Measure Medical Practice Capability

Do the state's current medical statistics present an accurate picture of medical care delivery in Wisconsin?

The physician partnership at the Hartland Clinic believes it does not, mainly because state data comes only from hospital discharge summaries.

In explaining the reasons for a study they did last summer, MDs R. K. Chambers and Clarence Samuelson of the Hartland Clinic point out that the state's method of data collection "obviously left out the main facility which delivers the majority of care, that is, the physician's office or clinic."

The Hartland physicians made a 47-day survey of their own practice last summer with some help from University of Wisconsin medical student David Nichols. Nichols was then a sophomore spending a summer clerkship at the clinic.

The results of the survey show that only 30% of the physicians' patients were seen in the hospital, while 70% were seen in the clinic.

Additional findings were: (1) 59% females and 41% males were seen; (2) patients were seen in all age groups; (3) one-third of all the clinic visits were not scheduled; (4) 20% of the patients were seen by ancillary personnel; (5) 88% of all patients lived within a ten-mile radius; and (6) 51% of phone calls involved the physician's time.

In commenting on their findings, Drs. Chambers and Samuelson point out that the figures show their practice to be a family practice serving a local area. They stress that information on the 70% of patients cared for outside the hospital is "urgently needed in comprehensive health care planning."

Data for the survey was collected from patients' clinical record cards and from a tally of the telephone calls coming to the office. This data collection did not alter normal office routine or efficiency nor add any great amount of additional work.

The authors of the study state they "feel strongly that this type of survey is necessary to reveal critical and badly needed facts about the medical care system." They note that "medical profiles like this of each medical practice unit in the state would provide information in attempting to discover the most effective practice types. Such data would influence formation of more effective practice units."

The authors say that "this data would better assess the actual number of physicians in an area that are delivering patient care."

The authors propose a statewide attempt at making similar surveys. They say this could be done by sending each physician a patient roster book with tear out sheets. These could be mailed to the State Bureau of Medical Statistics, then compiled and arranged at that location.

They say, "This study could run for approximately two months out of a year and would involve a minimal amount of time on the part of the individual doctor's office or the Bureau of Statistics. The value of such information obtained by this method would give the hard facts that we feel are so necessary in continued planning for improvement in medical care."

Legislative Crisis

PRESIDENT'S PAGE

ASSEMBLY BILL 1391 has been presented to the Legislature to abolish that portion of the fee splitting law that prevents hospitals from employing physicians. This is at the request of the Governor and originates from his Task Force personnel.

Let us consider how this could affect our patients and our practices.

There certainly is no assurance that it will lower cost. There are many services that cost more in a hospital setting than in a private practice. It opens up another avenue through which hospitals can make money, in this case at the patients' and doctors' expense.

Improved patient care and quality of care? It is very questionable that domination by nonmedical persons would raise quality. Individualized health care would suffer. Employed physicians would be less objective in determining quality of care. Physician productivity could decrease under regulated work week and working conditions. A further maldistribution of physicians would result where larger and more affluent areas could draw physicians from smaller communities. The free choice of physician would be a thing of the past.

Hospitals say that they are only interested in this to allow them to provide emergency service. However, in the next breath the doctors who by specialty are hospital associated are condemned and accused of receiving too large incomes.

Don't be deceived. Emergency room services are only the first step. From there it is only a short jump to the employment of physicians in all services; employed physician control of hospital staff; and then closed hospitals.

The Governor says it is necessary to revise the law so that hospitals can operate health maintenance organizations. Are hospital administrators totally capable of determining all health care needs, quality of care, and above all, making professional decisions relative to patient care? I don't believe they are!

The present law states that a physician is to exercise his professional judgment without supervision or interference by a hospital. I think this is the critical point of the entire question. The very essence of quality care depends on the freedom to exercise professional judgment and the preservation of this basic premise must guide all of our decisions.

G. A. Behnke M.D.

G. A. BEHNKE, MD

the WISCONSIN MEDICAL JOURNAL
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EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

El Momento de la Veritad

A LITTLE STUDY OF THESE WORDS will enable the medically trained reader to recognize the Spanish version of "the moment of truth." The notion contained in this classic idiom has to do with bull fighting. More specifically the expression takes notice of the split second when the ritual of bull fighting has reached its turning point, when the dance and the elegant, predetermined forms are left behind, and the bull fighter aims at finishing the struggle. The newspapers acclaim (or reject) the artistry of the ritual itself, so that the momento de la veritad becomes anticlimactic, if not really secondary.

Most of us are not personally familiar with the drama of the Spanish bull ring, but we can understand the mounting excitement as the man taunts the bull, with color, with glittering metal, and with clever acrobatics. Then when the final moment nears, the bull is reduced to impotent rage, his nostrils filled with blood. At this very point the matador shows his disdain for the frantic, dying bull by falling to his knees, right in front of the horns, and with raised dagger ends the life of the exhausted bull. The moment of truth is possible because the man has danced the bull to furious death.

At the risk of carrying an analogy further than it can bear, I would like to suggest that we in medicine are today being taunted under the "hot suns" of medical practice in America. We talk about our medical discoveries—and the governmental forces point out that they can do it better by agencies reporting directly to the President, as with the new cancer research bill. We talk about our devotion to our patients—and the private sector points out how few persons really are able to see a physician. We correctly reflect the excellence of our knowledge-producing medical schools—and professors of all sorts point out that other countries have better supplies of doctors and lower disease rates. And so it goes in one area after another.

In writing these editorials the real problem is selection of which issues are currently important. The hapless bull in a Spanish ring has our empathy if not our sympathy. We, too, are beset on all counts and so easily infuriated that we are sometimes sorely tempted to rage at the injustice of it all. From our point of view we have labored long and hard to get through medical school in the first place, then into practice, and finally into the community. As the attack on American medicine, the so-called "coming war on medicine," continues, we can choose several roads. Which one we choose affects in turn the next response of the opposing forces, and it may even determine whether we become part rather than parcel of the evolving health delivery system.

The most primitive response is rage. This reaction is common to man and bull, but the successful matador resists and so conquers the raging bull deftly and dramatically. We went through something like this over a decade ago, with the medicare legislation. It was not the "momento de la veritad," but it may well have signaled to the gathering crowds, both popular and governmental, that this was the route to our destruction, or at least toward subjection well out of the fancied role of autonomous power.

A second way to handle strong opposition is to rise above it. To rest comfortably above it all is enviable and lends itself to self-righteousness, if not to arrogance. Somehow I suspect that the bull is tempted to disdain the antics of the fighter and even of the bloodthirsty crowd, if only he could. We can, and do, sometimes turn this way. I suspect that careful opponents rejoice when we do so, for arrogance is a sure sign of fear. The clever antagonist, out for a score, will even goad for more and more spirals of righteousness, then move in for the kill with a rapid satire on our own words.

There are, of course, many ways to meet consistent threat. To identify each item and to analyze it completely and calmly seems one sensible way, as was done last month with the Milwaukee forty medical students' credo. If we can rise above the rage of the taunted bull, we may have an even chance to survive. Two examples follow:

1 It is gradually dawning upon the consciousness of the American public that it has been overdosed, not necessarily to its advantage. Even President Nixon has begun to link alcohol usage, tranquilizer prescriptions, and the general medical use of chemicals to the growing problems of drug addiction, to the "harder" drugs. Wisconsin's Senator Gaylord Nelson has publicly talked on the subject of drug intake to determine what can and should be done. Even physicians, such as Dr. Robert Seidenberg, a psychiatrist from Syracuse, have carefully studied the advertisements of pharmaceutical houses for assumptions that the stresses of everyday life—raising several children, practicing medicine, or teaching school—constitute psychiatric disease and need specific medicine—uppers or downers or something else. Henry Lennard, a research sociologist, has written extensively on "mystification and drug abuse" in which the public is exposed to the persistent notion in medicine that a pill can cure anything. Any practitioner knows all this, but how do we react to the growing charges that we overmedicate and that this somehow starts the vicious drug cycle, including TV drug ads? Shall we be aloof, or shall we heatedly rise and oppose, or shall we carefully study our own selves and meet the issues directly?

2 Howard Leventhal, PhD, writing in the June 1971 issue of the JOURNAL OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, has opened up the subject of "fear appeals and persuasion." In this scholarly report he begins a study of which methods suit better to change health habits, for example smoking. We are familiar with warning systems and horrible examples of the dangers of smoking, of driving carelessly, of drinking alcohol to excess, and of taking some drugs. At present the sophisticated judgment—whether scare techniques are best, whether positive reinforcement might serve more effectively, or whether some other method could be found—remains academic. Within a few years the Association could explore another "public versus physician" problem. When this happens the case will be tried in the newspapers, in magazines, and not in the clinical laboratory. Issues like this are first noticed in direct patient contact and noticed by most alert physicians. It becomes a political issue when ridden by some Nader-type individual or group, for his own personal reasons, and allowed to fester by medical failure to meet the issue directly and firmly, or by diversion as explained above.

What stance can we take on this one?—RH

The Medical Preceptorship in Wisconsin

IN THIS ISSUE DOCTORS Sivertson and Meyer, both deans in the University of Wisconsin Medical School, have presented us with the results of their survey of a number of physicians who have taken part of their training in the preceptor system. In some form this system has been used since 1926, although the preceptor thesis is as ancient as medicine itself. While the article is not in the classical sense a research effort, having no complex statistical tables nor chemical formulas, it deserves special reader attention for several reasons.

In the lesser sense, it is a carefully prepared progress report on an established teaching program at a major medical school. The complaints and the compliments will sound familiar to anyone who has worked with students in any setting, private or public, office or hospital.

In the larger sense, the article draws sharp attention to the rather inadequate use of medical training resources within the State of Wisconsin. Milwaukee County alone has over 1,500 practicing physicians, and the state has over 4,600 in total. Yet, only 17 physicians are listed as preceptors in this UW program. Perhaps not all physicians care to teach young doctors. Perhaps some do not have

the added skills, beyond actual medical knowledge, to be effective teachers. But 17 out of thousands!

In my years as chairman of psychiatry in our local medical school, I made serious attempts to engage the private sector in teaching. The results were mixed, and for the most part unsatisfactory. In some sense Doctors Sivertson and Meyer may fare better by going directly to the private sector rather than trying to draw the practicing physician to the institutions, as we did in Milwaukee. With the fierce pressure to produce more doctors, or perhaps to wrest the process from our control unless managed soon, we should give real attention to studies like this one. In spite of the flaws, medical education was obtained by these young men, and given by the 17 physicians. The sad part is that so few are used. If we insist on using only researchers for teaching young doctors, according to the internal trend in medical schools today, we may just never force enough young people through this formal mold. If so, we will fall flat on our faces in trying to supply the needed and competent physicians. Routing through existing knowledge-producing schools, admirable in itself, may be a tactical error. At least it could be a serious threat to medicine itself, to limit all training to one simon-pure form.

—RH □

MINUTES OF COUNCIL MEETING

MADISON, JULY 31, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:00 p.m. on Saturday, July 31, 1971, at the Society.

Voting members present were Doctors Galgano, Huth, Nordby, Davenport, Edwards, Dettmann, Mauthe, Rohde, Heinen, Lewis, Manz, Williams, Egan, Foley, Schmidt; Past President McRoberts, President Behnke, and Speaker Nereim.

Others present: Vice-speaker Hamlin; Doctors Bell, Galasinski, Picard, Carlson, Twelmeyer, Russell, Kief, Simenstad, Headlee, Bein, Derus, (for special order); Messrs. Thayer, Koenig, Brower, Maroney, Murphy, Crownhart, McManus, medical student Lueck; Mrs. Anderson and Miss Pyre.

Chairman Nordby administered the oath of office to Councilor DeLore Williams.

2. Approval of Minutes of May 8 and 11, 1971

On motion of Doctors Dettmann–Rohde, carried, these minutes were approved.

3. Guidelines for Staffing Mental Health Facilities

The Council discussed the text of guidelines as prepared by the Division on Nervous and Mental Diseases setting forth recommended staffing of mental health facilities, headed by a physician and preferably a psychiatrist. The proposal used the word "administrator" for this top position, and the staff organization chart also includes a "hospital administrator" and a "medical director." Clearly to distinguish between these positions, the Council amended the guidelines to designate the head of the complex as "general administrator." At the suggestion of Doctor Egan, the Council also approved incorporation of a statement of intent that all decisions in the medical care of patients will be made by duly licensed physicians.

On motions of Doctors Egan–McRoberts, carried, the guidelines were approved as amended, Doctor Mauthe voting in the negative.

4. Section on Plastic Surgery Membership Requirements

On motion of Doctors Davenport–Schmidt, carried, the Council approved the following qualifications for membership in the new scientific section:

Initial: All present members of the Wisconsin Society of Plastic Surgery.

Future: All members of the State Medical Society of Wisconsin who are diplomates of, or who are eligible for, the American Board of Plastic Surgery.

It is understood that, as with all sections, the scientific meetings will be open to all members in good standing of the Society.

5. Report of Commission on Medical Care Plans

Doctor Dessloch submitted a written report which was read and discussed by Mr. Koenig.

(Note: The report as distributed will be incorporated in the published minutes [see page 35].)

On motion of Doctors McRoberts–Dettmann, carried, the Council commended the report and noted especially the favorable administrative expense ratio.

6. Report of Executive Committee

A. Wiscansin Nurses Assaciatian

The committee reported for information on the institution of meetings with representatives of the Wisconsin Nurses Association to explore joint practice areas, concepts of health care delivery systems and proposed extension of the nurse's role. The next meeting will be in September with the Commission on Hospital Relations and Medical Education, and it is anticipated that an ad hoc committee, with representation from the Council, will be created to continue discussions with the nurses.

B. Health Care Review, Inc.

The Council received a July 30 revised draft of proposed articles of incorporation and bylaws of Health Care Review, Inc.

In discussion, it was suggested that the basic principle of peer review be incorporated in the purposes by appropriate wording. In connection with composition of the board of directors, the Executive Committee reported that this had been carefully considered, and there had been discussions that morning with officers of the Wisconsin State Dental Society.

On motion of Doctors Foley–Davenport, carried, the Council agreed that the initial board represent medicine, dentistry, hospitals, and one public member with broad civic interest.

On motion of Doctors Egan–Rohde, carried the Council accepted the material as a progress report pending consultation with other interested parties.

C. AMA Alternate Delegate Vacancy

On motion of Doctors Edwards–Huth, carried, the Council adopted the recommendation of the Executive Committee that E. M. Dessloch, M.D., be appointed to the unexpired term of Doctor Fox as alternate delegate to the AMA.

D. Work Week of Health

The committee reported it had approved the general format for October 19–22, 1971, and an estimated budget of $5,000.

E. Emergency Medical Care

In commenting on discharge by the Council of the Committee on Disaster Medical Care, the House of Delegates had suggested that the Council seek to assure the development of programs for emergency medical technicians and facilities to provide emergency medical care and deal with natural or military disaster.

The Executive Committee noted that emergency care in the hospital is in the jurisdiction of the Commission on Hospital Relations and Medical Education, and the Commission on Safe Transportation is concerned with that aspect of emergency care. It is recommended that any other matter that comes up on an emergency basis be handled through the Executive Committee of the Council, the Planning Committee being assigned any long-range problem that is outside the jurisdiction of the two Commissions.

Doctor Galasinski spoke of the AMA Committee on Community Services and its encouragement of state societies to reactivate interest in emergency care for all accidents at the county or community level, and to coordinate such local functioning. It was suggested that the two Commissions are presently engaged in this work.

On motion of Doctors Egan–Dettmann, carried, the recommendation of the Executive Committee was accepted.

F. Comments on Treatment

On motion of Doctors McRoberts–Schmidt, carried, E. C. Albright, M.D., was appointed to succeed Ovid O. Meyer, M.D., as co-editor of Comments on Treatment in the *Wisconsin Medical Journal.*

G. Annual Meeting Admission Policy

An administrative policy exists that nonmember physicians may be admitted to the scientific exhibits and sessions upon payment of a $25 registration fee. In the belief that this is an unrealistic amount as compared to membership dues, and although the occasion of its application is infrequent, the Executive Committee recommended that the nonmember admission fee be $100.

On motion of Doctors Schmidt–Foley, carried, the recommendation was approved.

H. Waiver of Dues at Age 70

The Medical Society of Milwaukee County reported action it had taken to waive dues at age 70 for physicians still in practice and not eligible for associate membership, and recommended that the State Society do the same.

The Executive Committee recommended that the Council propose a bylaw amendment to waive dues at age 70 upon individual application.

On motion of Doctor Foley–Davenport, carried, this recommendation was approved.

REPORT OF THE COMMISSION ON MEDICAL CARE PLANS TO THE COUNCIL—JULY 30, 1971

The Commission and its Prepaid Group Practice Committee have spent a considerable amount of time keeping abreast of health care experiments being conducted throughout the country, as well as those within Wisconsin. A number of medical communities have requested information and advice of WPS regarding possible experimental programs that would include a broad range of out-of-hospital health insurance benefits. Based on these inquiries, the Commission has approved an experimental "Health Maintenance Program" designed to obtain knowledge and experience with a new health care delivery and pre-payment mechanism.

The program includes an insurance benefit for nearly all services provided, supervised or directed by a physician, including services in his office, the outpatient department of the hospital, prescribed drugs, visiting nursing services, cost of materials and supplies, as well as the basic health insurance benefits for in-hospital care which currently represent the usual employer insurance package.

It is expected that reimbursement for at least the out-of-hospital services will be accomplished through an advance monthly payment to each physician for all patients selecting him as their family physician, eliminating the necessity for the extensive "paper work" now required in reporting small cost services such as routine office care. Through active claim review by the physicians involved, it is anticipated that costs for this broader range of benefits might not exceed the current cost of a more limited contract. With the availability of the out-of-hospital benefits, it is anticipated that preventive care might ultimately result in less hospitalization, or at least the experiment will provide some insight into whether or not this is a possibility.

The plan contemplates a patient's free choice of physician, with the decision to participate being left to each physician in the medical community.

This program is currently under discussion by several county medical societies. The plan has been designed so that, with some modifications, it could qualify as a health maintenance organization if it were desired to experiment with current (Medicare–Medicaid) or newly developed governmental plans.

The subject of uniform coding and procedure terminology has been under consideration by the Commission; and, by referral from the House of Delegates, a review of all current coding systems, including the AMA 5-Digit System, will be accomplished and action reported to the Council.

The Commission has taken the position that WPS contracts do not include a benefit for the payment of sterilization procedures other than those performed for therapeutic reasons. Because of the difficulty in obtaining a uniform interpretation of those sterilizations that do qualify for payment in various medical communities, the matter has been referred to the Commission's State Committee on Utilization Review for its advice.

A three-year Insurance Department examination has been completed covering WPS operations, including a financial audit. The report contained no criticism of WPS operations, but included some suggestions regarding content of advertising material. These are being discussed with the Insurance Department and implemented where it is agreed that improved advertising copy will result.

The Commission is pleased to report that administrative expenses are being well controlled and cost reductions accomplished where necessary to stay within budgeted goals. The financial condition of WPS is sound. The statement covering the first six months of the year indicates the plan is being operated with an excess of over $500,000 as a deposit to reserves after all claims and administrative costs had been paid, including an amount set aside for unreported claims for services that were rendered in the first half of the year.

The Commission has watched the development of national health insurance proposals and will provide the Council with recommendations at such time as detailed consideration is indicated.

E. M. Dessloch, MD
Chairman
Commission on Medical Care Plans

I. Off-Hour Elective Care

The AMA, in attempting to implement an action in June 1970, is asking state societies to provide information on various methods or systems now in operation that have been developed by physicians, medical societies, and other health providers—not connected with hospital emergency rooms—to meet the needs for off-hour elective and semi-elective care.

The Executive Committee reported its belief that the hospital is probably the most efficient place for such care, and in any event, such arrangements are a matter of local option. It suggested that no comment be made as to the development of alternative systems.

On motion of Doctors Davenport–Dettmann, carried, the recommendation was accepted.

J. Financial Support for Health Planning Organizations

A specific request had been received from one of the eight areawide health planning organizations in the state for financial support from the Society or its WPS insurance division.

On motion of Doctors Dettmann–Foley, carried, the Council agreed they should be advised that while the Society supports health planning and encourages physician participation, there are no funds available for grants to these organizations.

7. Report of Commission on Public Policy: Doctor Russell, Chairman

The Council received a report on the status of major legislation with which the Society is concerned in the current session. (This was printed in the August GREEN SHEET section of the *Journal.*)

Doctor Russell discussed plans for a special meeting of the Commission to explore in depth a legislative action program for the balance of this session and the next. He said members of the Council would be welcome, and there was also general agreement with the suggestion of Doctor Nordby that representatives of county medical societies also be invited with a view to stimulating action at the local level.

8. Report of Commission on Scientific Medicine: Doctor Derus, Chairman

Doctor Derus presented two recommendations of the Commission for Council consideration: that the 1972 scientific program be reduced to two days, Monday and Tuesday, May 8 and 9, at the Sheraton–Schroeder and Milwaukee Auditorium; and that the Council explore the possibility of the House of Delegates meeting at a time and place other than when the scientific meeting is presented.

The results of a recent survey of members of the House of Delegates were distributed, indicating that in 1971 a significant number of delegates did attend scientific sessions. In addition, discussions of the Finance Committee that morning were reported with the recommendation that an ad hoc committee be appointed to review past experience in the conduct of annual meetings, innovations that have been tried before as to time of year, days of the week, location, etc., and to make recommendations for the future inasmuch as commitments have been made through 1974 and in light of the prospect of new facilities being available in Madison by 1975.

In discussion of the proposition of a two day meeting in 1972, question was raised as to the effect on exhibitors and on various social events and affairs of specialty organizations. Doctor Derus was asked if the Commission would compromise on a two and a half day meeting, and he indicated that while it would like to try a two day scientific meeting, the compromise would be acceptable.

On motion of Doctors Edwards–Manz, carried, the Council approved a two and a half day scientific meeting for 1972.

Mr. Thayer stated that while the Council had recommended that the 1975 meeting be held in Madison, the House of Delegates had not acted on this suggestion. Nevertheless, he proposed that with the prospect of new facilities being available by then, contact be made on a preliminary basis to put in a bid for space in 1975. He was reminded that Mother's Day is to be avoided if possible.

On motion of Doctors Dettmann–Foley, carried, the Council directed that such contacts be made.

9. Report of Committee on Economic Medicine: Doctor Schmidt, Chairman

A. Review of Society Insurance Programs

The committee reviewed present insurance programs sponsored or sanctioned by the Society, and suggested that at least annually the membership be reminded of the programs available to them as members, perhaps in the GREEN SHEET with reprints available for direct mailing.

On motion of Doctor Schmidt, seconded and carried, this recommendation was approved by the Council.

It was also suggested that at such time as there is a change in any of these programs, individual members be informed explicitly of their present coverage and the effect of the change. It was agreed this should be handled with the company involved.

B. Professional Liability

The committee reported it had reviewed the questionnaire to be sent to the membership in a concerted effort to acquire information believed necessary in order to proceed with negotiations for a group professional liability insurance program. Such a survey had earlier been authorized by the Council.

It was also recommended by the committee that adoption of the Pennsylvania plan in reference to professional liability coverage and claims be pursued with the Wisconsin Commissioner of Insurance.

On motion of Doctor Schmidt, seconded and carried, this recommendation was approved by the Council.

10. Report of the Finance Committee: Doctor Dettmann, Chairman

Doctor Dettmann reported that the committee had reviewed budget performance for the first six months of 1971 and experience was what might reasonably be expected. The committee had received information on the outlook for pharmaceutical advertising which was not optimistic, and suggested a direct approach to pharmaceutical companies to make them aware of the high readership rating of the *Wisconsin Medical Journal.*

He reported that action of the Council in March relative to assumption of health insurance premiums for employees 65 and over would be referred to the actuary for review inasmuch as the financial impact may not have been fully appreciated.

He referred to the earlier report of the committee's discussion of the annual meeting format, including financial implications, and the recommended creation of an ad hoc committee.

On motion of Doctor Foley, seconded and carried, this recommendation was approved by the Council.

(Before adjournment, Doctor Nordby announced appointment of the following to constitute the ad hoc committee on the annual meeting: Drs. T. J. Foley, Milwaukee, chairman; R. F. Lewis, Marshfield; G. J. Derus, Madison; N. O. Becker, Fond du Lac; G. A. Berglund, Milwaukee; and S. B. Gundersen, Jr., La Crosse.)

On motion of Doctor Schmidt, seconded and carried, the report of the Finance Committee was accepted.

11. Report of Consultants

Mr. Crownhart discussed his role as one of consulting with staff in the process of drafting reports and mechanisms, and of looking to the future of organized medicine. He mentioned as an example that in discussions of liability insurance, the "no fault" approach had not yet been considered.

Mr. Murphy enumerated the many laws and regulations that affect operations of the Society in its broad scope of activities which necessitate continuing legal advice.

12. Medical Assistance Advisory Committee

Doctor Galasinski reported to the Council for information as a member of this committee advisory to the Title XIX Medicaid Program.

13. AMA Delegates' Report

Doctor Galasinski reported for the delegation, and requested support of the Council in drafting a resolution for introduction at the next meeting of the House of Delegates, to be forwarded to the AMA House of Delegates, making it mandatory that all resolutions be submitted to the AMA thirty days before its sessions.

The delegation had also discussed the matter of compulsory AMA membership, in light of recent publicity concerning a Wisconsin physician's resignation from the AMA. The delegation is in favor of compulsory AMA membership and asked for an expression from the Council, and possibly the House of Delegates, with the further suggestion that a white paper be developed stating the positive benefits that derive from AMA membership.

14. Hospital Award Nominations

Mr. Thayer reported that no nominations had been made by councilors of hospitals to be considered for the community achievement award, and in the absence of such nominations, he assumed the award would not be given in 1971.

15. November Council Meeting

The Chairman proposed the date of Thursday, November 18, for the next Council meeting, with necessary committee sessions being held that morning or the evening preceding. No objections were expressed from the Council.

16. Report of Secretary

A. Mr. Thayer reported that Doctor Callan had been appointed by the Governor to a full term on the Council on Health.

B. A status report on May 1971 House of Delegates actions was distributed for information of the Council.

C. Governor's Health Planning and Policy Task Force

Mr. Thayer reported on the second meeting of the Task Force at which the hundreds of suggestions made at the first meeting as to what were believed to be the "major barriers" to health care were reduced to seven or eight basic goals. He announced a series of eight public hearings to be held around the state between August 10 and September 2, to be followed by another Task Force meeting on September 13 after which a preliminary report will be made to the Governor.

D. United States Chamber of Commerce

Mr. Thayer informed the Council of a slide presentation on "Health Care: The Great Debate" being made available to local chambers of commerce, and urged local physicians to contact their chambers of commerce to discuss the subject.

17. Slide Presentation on Organization of the Society and Adjournment

The Council adjourned to the Presidents Room at 5:30 to view the updated slide presentation on organization of the Society and its affiliates.

Respectfully submitted:
EARL R. THAYER
Secretary

Approved:
E. J. NORDBY, MD
Chairman

(Subject to formal approval of the Council.) □

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Student Evaluation of Medical Preceptorships

UNIVERSITY OF WISCONSIN MEDICAL SCHOOL

By S. E. Sivertson, MD and T. C. Meyer, MD
Madison, Wisconsin

IN 1926, THE MEDICAL SCHOOL of the University of Wisconsin began an experiment in Medical Education. Simply stated, it combined an academic curriculum with the old preceptor system. More specifically, it brought to the student, valuable contact with an experienced, able practitioner (the nebulous art of Medicine at a grass root level was made real), the intricacies of competitive practice and the influence of circumstance and environment on solving patients' problems. Historical reviews and periodic evaluations of this program were documented on several occasions:[1-8] each confirmed a decision for continuation and the experiment has survived 45 uninterrupted years.

But what of the student's reaction to preceptorship at the moment of completion? In what way did he see himself benefiting? Did it influence his future plans? These inquiries, and many more, have always challenged proponents of preceptorship; but without objective data answers remained matters of opinion. To get data therefore, a questionnaire was designed which each senior student (class of 1970) answered upon completion of his preceptorship.

Before proceeding to the questionnaire, a word about the preceptorships and student orientation to this program is indicated.

Preceptorships

There are seventeen full-time private practicing physicians (preceptors), located in different areas of Wisconsin, who receive one or more senior medical students on regular assignment every three months throughout the year (Table 1). Each preceptor has associate preceptors who are members of a cooperative group or clinic and to whom he can assign the student for varying lengths of time. Preceptorships range in size from 2 to 90 physicians and are divided into three types: (1) Family Practice [FP] of which there are five, (2) Mixed Practice [MP], which combine family practitioners with specialists in the same group, a total of five, and (3) the remaining seven are Specialty Practice [SP] groups. Consequently, they vary in character from family practice in small rural communities to specialty groups in metropolitan areas. Sixteen preceptors are surgeons, internists, and family practitioners; the seventeenth is an obstetrician and gynecologist. Within his setting, a preceptor can design a curriculum based, to some extent, on the expressed wants and needs of the student.

Orientation and Selection

Each class participates in an orientation program to preceptorship in its junior year. Following orientation a student is required to evaluate his own needs and request assignment to the preceptorship(s) most likely to meet his needs.

Doctor Sivertson is Assistant Dean and Director of Preceptorship Program; Doctor Meyer is Associate Dean, University of Wisconsin Medical School.
Reprint requests to: S. E. Sivertson, MD, 610 North Walnut St., Madison, Wis. 53705.

Preceptorship is generally required of all senior students, but some exceptions for unusual reasons do occur. In the 1970 class of 93 there were 13 such exceptions. The exceptions were illness, family circumstances, work toward a PhD, acceptance or an award in a special program outside the regular curriculum.

TABLE 1—*Preceptors—1970*

Family Practice (FP)	
H. S. Ashe, MD	Woodruff
P. T. Bland, MD	Westby
R. L. Hartzell, MD	Grantsburg
B. C. Prentice, MD	Ashland
M. L. Whalen, MD	Bruce
Mixed Practice (MP)	
W. S. Bump, MD	Rhinelander
E. E. Eckstam, MD	Monroe
R. L. Gilbert, MD	La Crosse
R. B. Larson, MD	Wausau
M. J. Lustok, MD	Milwaukee
Specialty Practice (SP)	
D. R. Griffith, MD	Eau Claire
B. R. Lawton, MD	Marshfield
W. A. Morgan, MD	La Crosse
F. E. Murray, MD	Milwaukee
H. F. Sandmire, MD	Green Bay
R. M. Senty, MD	Sheboygan
H. M. Snodgrass, MD	Janesville

Response to Questionnaire

Sixty-three (75%) of 80 students completing the preceptorship answered the questionnaire. The questions and answers with some interpretive comments follow.

1. Were your responsibilities made sufficiently clear to you?

Yes—58 (92%)
No—5 (8.0%)

It would appear that all preceptors made an attempt to orient the student to his responsibilities during preceptorship and did so to the students' satisfaction in most cases.

2. How were your patients divided?

The average of the class response was as follows:
Surgery—27.4% (range 2% to 70%)
Medicine—44.6% (range 5% to 100%)
Gynecology and Obstetrics—10.2% (range 2% to 50%)
Pediatrics—12.1% (range 1% to 60%)
Psychiatry—5.7% (range 1% to 20%)

As might be expected, surgical and medical patients commanded most of the students' attention. Unless a student has an interest in Pediatrics, OB/GYN or Psychiatry or feels he has deficiencies in certain areas and requests to see these types of patients, his exposure to them is limited.

The range of response indicated a high degree of adaptability in the program. For example, three students with strong interest for Internal Medicine selected programs permitting them to see medical patients exclusively (100%); others, with little interest here saw few medical patients (5%).

3. How was your time spent?

In hospital operating room—21% (range 1% to 33%)
In hospital (rounds, histories, physicals, emergency room)—42% (range 5% to 90%)
In office—36% (range 1% to 75%)
On house calls—1.6% (range 0% to 10%)

Class response here revealed that most time was spent in the hospital dealing with those patient problems which required hospital facilities. About one-third of the students' time dealt with office patients either returning for follow-up examination after dismissal from hospital, or whose problems could be dealt with on an outpatient basis. In addition, it gave students exposure to office management procedures. The small exposure to house calls probably reflects the trend in Wisconsin to see patients in the physician's office and hospital emergency room rather than the patient's home. Response to this question again demonstrated considerable range of possibilities matching interests of students with strong points of a preceptorship.

4. How many histories and physical examinations did you average a day?—2.7 (range 0.2 to 30)

The nature of a "work-up" was not defined in this questionnaire. Conversation with students, however, indicated that usually it meant one to three detailed history and physical examinations. In those responses indicating 30 per day most students meant short histories and physical examinations for minor patient problems. In general the number of "work-ups" did not appear excessive.

5. What were the major advantages of your preceptorship? (The class ranked the following options listed on the questionnaire in this order of importance):

(1) Increased contact with acute disease. } (40–53%)
(2) Chance to assume greater responsibility. }
(3) Close teacher–student relationship. } (17–20%)
(4) Opportunity to see ambulatory patients. }
(5) Other—negligible.

"Increased contact with acute disease" was ranked either number one or two by 43 (53%) students and "chance to assume greater responsibility" was rated either first or second by 32 (40%) students.

"Close teacher student relation" ranked either first or second by 16 (20%) students, while "opportunity to see ambulatory patients" was put in these positions by 14 (17%) students.

The gap between these two groups (40–53%) and (17–20%) was considerable and highlighted the areas of greatest value to the student. "Increased contact with acute disease" reflected the student's recognition of the lack of patients with acute disease in the University Medical Center which deals primarily with chronic, complicated, and esoteric long-term illness. These opinions duplicate the student reaction noted by Bowers and Page[1] ten years ago. The nature of acute disease seen in preceptorship ranged from minor to major, varied from acute respiratory infections to severe trauma and complemented in many ways experience with the University Hospitals' patient population.

The ratio of one student working closely with one preceptor permitted close supervision of a student's work and with sufficient time, allowed the student to assume greater responsibility. Preceptorship should be conducive to this and the students' response here suggested, that indeed, it was.

6. Did the amount of routine work reduce the educational value of the preceptorship?

Yes—12 (19%)
No—51 (81%)

Although this questionnaire did not define routine work, comments by students on this point usually referred to routine ventipuncture, well-baby examination, preschool examination, immunization, insurance examination, and general check-ups which, although constituting a bulk of private practice, did not stimulate the student's romance with exotic disease and beguiling pathophysiology. The 81% of the class that responded negatively to this question might be an expression of maturation to the realities of community health care.

7. How could your preceptorship have been improved?

28%—more student responsibility
21%—more contacts with specialists and special patients
15%—longer time at preceptorship
11%—more access to and better quality of reference facilities
8%—more time with secondary physician (or other doctors)
7%—improvement in living conditions
12%—miscellaneous

Both the response here (28%) and in question 5 point clearly to the students' desire for more patient responsibility. With close supervisory relationship between preceptor and student, this should be possible.

The students recommending more contact with specialists and special patients suggested that for them there was need for more depth of knowledge and skill in handling particular patient problems. The implication may be that preceptors did not provide it.

Additional responses to this open question ranged widely. Eleven percent pointed to poor medical libraries, and those referring to improved living conditions and monetary desires were a small minority.

8. Did the preceptorship influence your plans for the future in any way?

Yes—49 (78%), no—8 (13%), no answer—6 (9%)
(a) To specialize: yes—43 (76%), no—14 (24%)
(b) To enter family practice: yes—18 (31%), no—39 (69%)
(c) To enter academic medicine: yes—11 (19%), no—46 (81%)
(d) With respect to locality: yes—31 (55%), no—26 (45%)

A large majority of students who answered this question believed preceptorship influenced their future in some way. This influence took on several dimensions one of which was a push towards specialization, and consequently away from family practice and academic medicine. On the other hand this experience appeared to favorably influence a third of students toward family practice.

Bowers and Page[1] compared the effect of preceptorship and medical school clerkship experience on career plans and found no significant difference. This study made no similar comparison, yet the large percentage indicating a desire to specialize is hard to ignore. The decade saw a remarkable growth in clinic practice in Wisconsin; the number of physicians in small groups of general or family practitioners increased and included more specialists. The impact of this trend on preceptees may be reflected here.

Fifty-five percent of respondents thought exposure to community practice did influence their choice of a locality in which to live. We had no further information that would illuminate the direction of that influence.

Finally, the student was asked to comment openly about his preceptorship experience. Statements such as these were representative and informative:

"I felt I was a hindrance to an overworked physician."

"—stayed away from the office because the patient record, size of a prescription pad, was too small to write a satisfactory history and physical examination."

"Sisters running the hospital won't let the student do anything."

"Relations between several doctors here were not good and I felt it detracted from the program."

"Was not pleased with the general attitude of distribution of responsibilities—why hasn't someone complained?"

ON THE OTHER SIDE OF THE COIN:

"Learned that superb medicine can be practiced in a small community."

"Group practice is for me."

"What a relief to get away from the impersonal sterile atmosphere of academia."

"Great to work with men who know the breadth and depth of being a physician."

"The most meaningful part of my four years in medical school."

Each preceptor received a summary of his students' response to this questionnaire. He in turn reviewed it with his associates and made appropriate changes if possible.

The entire report was on the agenda of one of the semi-annual meetings of preceptors and faculty at the Medical School.

Conclusions

From this student evaluation questionnaire, the following inferences can be made:

1. Preceptors satisfactorily orient students to their responsibilities on preceptorship.
2. About three-fourths of the patient problems with which students dealt were medical and surgical.
3. Approximately 63% of student time was spent in the hospital and about 33% of student time was spent in the preceptor's office.
4. The number of "history and physical examinations" done by a student daily was approximately two to three.
5. From the student's standpoint the major advantages to preceptorship were "increased contact with acute disease" and "chance to assume greater responsibility."
6. About 80% of students believed that "routine work" did not reduce the educational value of preceptorship.
7. The most common suggestion for improvement of the preceptorship was "more student responsibility."
8. Approximately 78% of students believed that the preceptorship experience influenced their future plans in some way. The major influence was towards specialization, although about a third of the class was favorably influenced toward family practice.
9. The seventeen preceptorships were sufficiently varied so that they could accommodate personal interests of students in both specialty practice and in family practice.
10. The results of this questionnaire provided a mirror for each preceptorship. Viewed through the eyes of a student the program, and perhaps the practice of medicine, benefited.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the reoders and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

ACUTE RENAL FAILURE: Diagnosis and Management

By Robert C. Muehrcke, MD. The C. V. Mosby Co., Saint Louis, Mo. 1969. 343 pages. Price: $19.75

Since the publication of Dr. John Merrill's second edition of *The Treatment of Renal Failure* in 1965, there has been a very real need for a volume which would adequately cover the many aspects of acute renal failure. This volume is an attempt by one author to encompass this exceedingly complex clinical entity. Unfortunately, in certain aspects, Doctor Muehrcke has been less than completely successful.

I wish to first consider the positive aspects of this volume. For purposes of reference, the bibliography is incredibly complete with over 1,100 references cited. For this reason, the book will serve a useful purpose for students of acute renal failure as regards source material.

Secondly, Chapter Four regarding the etiology and pathogenesis of acute tubular necrosis is one of the stronger areas of the book with complete treatment of the various etiologies which can cause acute renal failure. There is an excellent table of the various drugs that might cause acute renal failure.

Chapter Five is a reasonable treatment of the management of acute renal failure with perhaps undue emphasis on the various types of dialytic treatment, complete with the history of dialysis, which I feel might be considered redundant.

Turning next to the principal criticisms, this reviewer believes that the principal deficiency of the book is in its style. There is a good deal of repetition with repetitive reference to the same article. There are also numerous grammatical and spelling errors, with incomplete sentences, reflecting less than optimal editorial management.

Because of the author's background and principal interest, there is, I feel, undue emphasis on the pathologic aspects of acute renal failure with an incomplete and distinctly lesser emphasis on the physiologic and pathophysiologic aspects of acute renal failure. Admittedly, a good deal of the recent information concerning the pathophysiology of acute renal failure has become available following completion of this volume. The reviewer does, however, feel that emphasis on the differentiation of so-called acute parenchymal renal failure versus so-called "prerenal" or hypoperfusion renal failure is inadequately stressed.

Finally, there are occasional statements relating to therapeutic approaches which lack scientific validation. The use of corticosteroids in the treatment of some types of renal failure is an example.

To summarize, this volume will serve a useful purpose for the nephrologist who desires a complete bibliography pertaining to acute renal failure. The medical student will find the last two chapters quite useful in improving his knowledge of acute renal failure. It will be a useful addition to any medical school or hospital library.—Weldon D. Shelp, MD □

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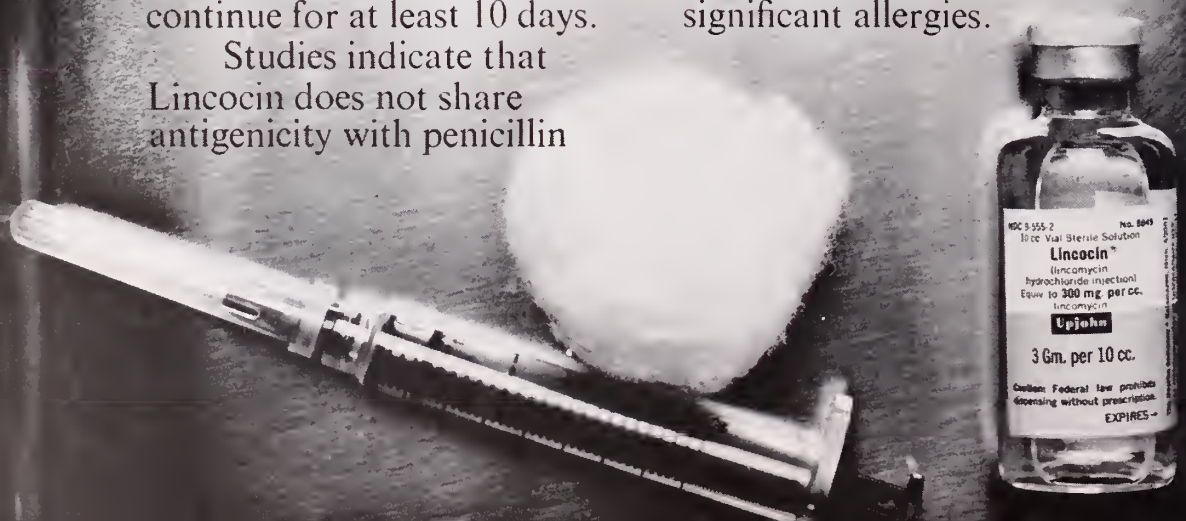

SECTION OPHTHALMOLOGY

OCTOBER 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

ALUMNI DAY IN MILWAUKEE

The annual Alumni Day of the Department of Ophthalmology of the Medical College of Wisconsin was held June 5 in Milwaukee. The interesting program was arranged again this year by Walter E. Gager, MD. Abstracts of the papers presented are as follows:

Pre- and postoperative use of prisms in strabismus: KENNETH S. FABRIC, MD. A summary of several case histories where the management of squint with the pre- and postoperative use of prisms were utilized. Preliminary conclusions revealed that there may be some use of prisms especially in the postoperative period if the aim of surgery is for full functional use of ocular fusion.

Rhegmatogenous nature of snail track degeneration: THOMAS R. STEVENS, MD. A series of patients with snail track degeneration of the retina was presented. Eight of 13 eyes involved had retinal detachments. Reviewed were the ages of the patients, lack of vitreous traction, and the positive family history in one patient.

One year of resident cataract surgery: DAVID F. SWEET, MD. Cataract operations performed at the Veterans Administration Center at Wood, Wisconsin, during the year 1969 were reviewed. Special emphasis was placed on technique, operative and postoperative complications, and the visual results over a one-to-two-year follow-up.

The treatment of toxoplasmosis chorioretinitis: DON C. SCHMIESING, MD. A review of the literature concerning the treatment of toxoplasmosis chorioretinitis was discussed, and a case of treated toxoplasmosis was presented.

Cyclorotoratory effects of horizontal recti translocation: EDWARD W. WALDECK, MD. An interim report of the continuing study of patients with horizontal recti translocation. Preliminary results are encouraging for the decrease and severity of certain "AV pattern strabismus."

Sympathetic ophthalmia, a literature review: DAVID S. HULL, MD. A review of the recent literature concerning etiology, mechanism treatment, and prognosis of sympathetic ophthalmia was presented.

Effective isometric exercise on intraocular pressure: DANIEL F. MARCUS, MD. Dynamic exercise has been shown to lower intraocular pressure. Static exercise using a hand-grip device has been shown to produce a similar hypotensive effect. This report reviewed the statistical analysis of the data gleaned from a series of patients utilizing the hand-grip method.

Cytomegalochorioretinitis—correlation virology and clinical course: THOMAS J. CESARZ, MD, THOMAS M. AABERG, MD, and MICHAEL W. RYTEL, MD. A case of an adult with cytomegalovirus infection with bilateral retinitis following a renal homo-transplantation was presented. The clinical course of his retinitis was correlated with viral studies and doses of systemic steroids.

Corneal polysaccharides and controlled rate freezing: VINCENT P. SAVAGLIO, MD. Excised rabbit corneas were subjected to the controlled-rate freezing process of Doctors Kaufman and Capella and were then subjected to biochemical analysis of mucopolysaccharide content using the phenol-sulfuric acid reaction. Controls for the experiment consisted of the same analytic method applied to fresh rabbit corneas.

Arcus senilis, clinical aspects and literature review: THOMAS F. TAYLOR, MD. A review of the pathogenesis and clinical aspects of arcus senilis including a review of the current literature was presented.

Exudative secondary retinal detachments following scleral buckling with cryotherapy: GENE J. PAWLOWSKI, MD. A series of patients with exudative secondary retinal detachments was reviewed. They were compared statistically with patients treated with diathermy vs. cryotherapy. Other statistical comparisons were made between non-exudative secondary retinal detachments and the incidence of occurrence of each with horseshoe tears, round holes, and round holes with opercula.

Soft contact lens—laboratory evaluation: HENRY EDELHAUSER, PhD. A review of the various types of soft contact lenses currently available was presented. The oxygen and water transport of each type was compared statistically.

Evaluation of cryopreserved corneal tissue: RICHARD SCHULTZ, MD. Surgical experience with 15 corneal transplant patients utilizing the cryopreserved corneal tissue was reviewed. Complications of postoperative course and ultimate results were presented.

See-saw nystagmus—case report and movie: J. CHIN, MD, and WALTER E. GAGER, MD. A case of spontaneous see-saw nystagmus in a five-year-old boy was presented. Surgical histopathological review of the case was performed. A literature review and presentations of the characteristics of see-saw nystagmus were presented.

VOLUNTARY DUES ASSESSMENT

The Executive Committee reminds all ophthalmologists that voluntary dues for the year 1971 are still being received. Voluntary contributions to the Section on Ophthalmology are used for projects specially designed to educate the public and others on medical eye care.

The regular voluntary membership contribution is $100. Educational membership contribution, for physicians who derive no part of their income from private practice, is $50.

Please make check payable to the Section on Ophthalmology, Box 1109, Madison, Wis. 53701.

DATES TO REMEMBER

Oct. 26: Milwaukee Ophthalmological Society. Speaker: Francis A. L'Esperance, MD, New York City.

Nov. 23: Milwaukee Ophthalmological Society. Speaker: Edward W. O. Norton, MD and Robert Machner, MD, Miami, Fla. □

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Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Rarely, necrotizing vasculitis, paresthesias, icterus, pancreatitis, and xanthopsia have occurred with thiazides alone.

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NEWS HIGHLIGHTS

Family Physicians Elect New Officers

Richard W. Shropshire, MD* of Madison was elected president-elect of the Wisconsin Academy of Family Physicians at the organization's annual meeting in Milwaukee Sept. 10–11.

Dr. Shropshire, 43, is the youngest member to be elected president of the 874-member association of family doctors in its 24-year history. Dr. Shropshire will take office as president in the fall of 1972. He will succeed Paul E. Wainscott, MD* of Menasha, who was installed as president at this year's annual meeting.

The Wisconsin Academy of Family Physicians has changed its name from the Wisconsin Academy of General Practice, reflecting the country-wide change in emphasis on training physicians in the new specialty of Family Medicine.

George V. Murphy, MD* of South Milwaukee was elected chairman of the Board of Directors. Nicholas F. Damiano, MD* of Hales Corners was reelected secretary-treasurer.

Other officers elected included MDs Marwood E. Wegner,* St. Croix Falls, speaker of the Congress of Delegates; William E. Hein,* Monroe, vice-speaker; Robert F. Purtell, Jr.,* Milwaukee; Richard Chambers,* Hartland; Henry C. Rahr,* Green Bay; and James N. Moore,* Madison, members of the Board of Directors; Albert H. Stahmer,* Wausau, delegate to the national organization; and George V. Murphy,* South Milwaukee, alternate delegate.

The state's family physicians passed several resolutions urging higher priority for the training of family physicians in Wisconsin. The Academy stated that Wisconsin lags in the training programs required to maintain the correct balance of numbers of physicians to population.

One resolution urged David Carley, chairman of the Governor's Health Planning and Policy Task Force, to appoint knowledgeable family physicians to the Task Force's subcommittees. Another resolution called on the Academy to "use every means at its disposal" to insure creation of full departments of Family Practice at the state's two medical schools. While many medical schools in the midwest, sensing the need for increased training of family physicians, have instituted family practice departments in their schools, neither the University of Wisconsin Medical School nor the Medical College of Wisconsin have such departments, the Academy emphasized. The Madison school has a small program affiliated with St. Mary's Hospital in Madison. There is no program for the training of family physicians at the Medical College of Wisconsin.

Dr. Wainscott

Dr. Shropshire

The Academy also passed resolutions urging the state legislature to base its funding for the Medical College of Wisconsin on the number of Wisconsin residents it accepts in the school, and urged a study of the feasibility of creating one or two two-year basic science schools in the state, to allow the matriculation of more medical students.

ECG Tracings Sent by Telecopier

In a matter of minutes, heart specialists at University Hospitals can now receive and read electrocardiogram (ECG) tracings sent to the UH from community hospitals in Wisconsin. The machine used is a telecopier, a small instrument capable of sending copies of printed matter long distances by telephone signal.

PHYSICIAN BRIEFS

T. H. Roberts, MD*
T. A. Keller, MD*

. . . Menomonee Falls and Brookfield, recently became associated with the Medical Associates in Menomonee Falls. Doctor Roberts graduated from the Marquette School of Medicine and completed his internship and residency training at Milwaukee County General Hospital. In 1968–1969, he served as Chief Administrative officer in surgery at Marquette Affiliated Hospitals. Doctor Keller has been in private practice in Milwaukee since 1967 and is a graduate of the Marquette University School of Medicine. His internship and residency training were completed at Lutheran Hospital, Milwaukee. He also attended the University of Wisconsin for a year of residency in diagnostic radiology.

Jerry W. McRoberts, MD*

. . . Sheboygan, recently was honored by members of the Sheboygan Clinic staff, their wives and special guests, for his services as president of the State Medical Society of Wisconsin during 1970–1971. Doctor McRoberts has been associated with the Clinic since 1935. Dr. Richard B. Windsor,* Sheboygan, served as general chairman for the occasion.

Charles P. Nichols, MD

. . . La Crosse, recently began an association with MDs Paul Dietz* and Ruth Dalton* in the practice of pathology at St. Francis Hospital. He graduated from Marquette University School of Medicine (now The Medical College of Wisconsin) and served his internship and residency at Milwaukee County General Hospital. Doctor Nichols served in the U.S. Air Force and also completed a two-year fellowship at the Mayo Clinic, Rochester, Minn.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

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George H. Handy, MD*

. . . Madison, recently was featured in "Know Your Madisonian" in the WISCONSIN STATE JOURNAL. Doctor Handy, Wisconsin's State Health Officer, is a 1942 graduate of the University of the Chicago Medical School and earned a Master's degree in public health from the University of Minnesota in 1965. Before his appointment to the Wisconsin Health Department he was in private practice in Wisconsin Rapids. Doctor Handy became interested in public health while serving as an officer in the U.S. Army Air Force during World War II.

Bernard Korbitz, MD*

. . . Madison hematologist who has been associated with the Monona Grove Clinic, recently accepted a position as Director of the Department of Medicine at Presbyterian Medical Center, Denver, Colo. He will direct the internal medicine training for an internship and residency program at the center and establish subspecialty training in hematology and cancer chemotherapy. Doctor Korbitz is a 1960 graduate of the University of Wisconsin Medical School and a former member of its faculty. He is a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians.

Nabil Kader, MD

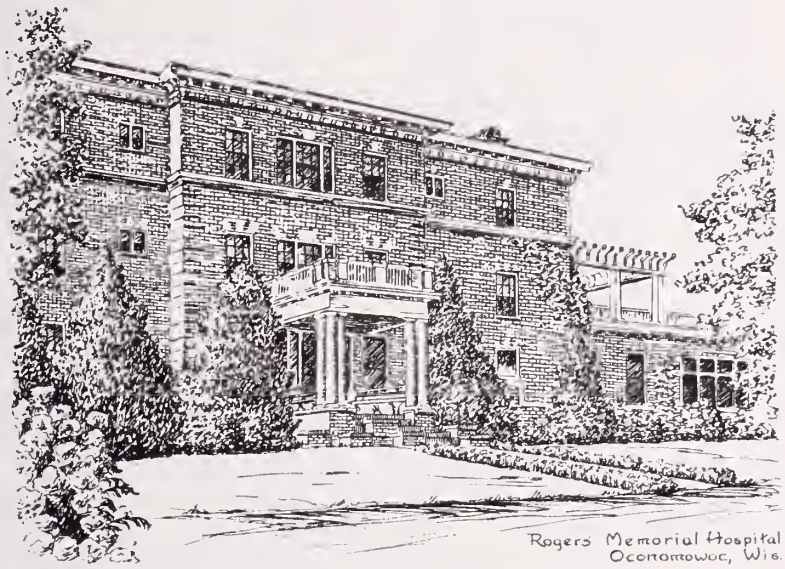
. . . La Crosse, recently joined the medical staff of the La Crosse Clinic. Doctor Kader received his medical degree from Ain Shams University, Cairo, Egypt, in 1956 which was followed by a three-year internship and surgical residency at Ain Shams University Hospitals. Doctor Kader is a fellow of the Royal College of Surgeons of Edinburgh, Scotland. Prior to joining the La Crosse Clinic, he completed a three-year residency in urology at the Cleveland Clinic, Ohio.

Warren W. Wright, MD

. . . Chippewa Falls, recently assumed the position of director of the Pathologic and Clinical Laboratories of St. Joseph's Hospital, Chippewa Falls. Doctor Wright graduated from the University of Tennessee College of Medicine, served a rotating internship at Baptist Memorial Hospital and had one year of general practice prior to entering the U.S. Army Medical Corps. He completed his residency at the VA Hospital in Louisville, Ky., and was assistant instructor at the University of Louisville School of Medicine. He also was an assistant professor at the State University of New York. Doctor Wright held the position of Chief, Anatomic Pathology Section, VA Hospital, Syracuse, N.Y., prior to his present position at St. Joseph's Hospital.

Alan J. Hay, MD

. . . Grantsburg, has joined the medical staff of the Grantsburg Hospital and Clinic. He is a 1970 graduate of the University of Wisconsin Medical School and had been associated with the United States Public Health Service Hospital, New Orleans, La., for the past year. He had previously served a preceptorship with R. L. Hartzell, MD* of the Grantsburg Clinic.



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Reynaldo Maniquiz, MD

. . . Chippewa Falls, recently became associated in practice with L. W. Picotte, MD* of Chippewa Falls. Doctor Maniquiz graduated from the School of Medicine of the Far Eastern University and served his internship at the University Hospital. He took a rotating internship at Swedish Covenant Hospital, Chicago, and served his residency at Weiss Memorial Hospital.

Richard Bonaldi, MD
Kap C. Kim, MD

. . . Wisconsin Rapids, recently became associated with the Riverwood Clinic. Doctor Bonaldi graduated from the University of Illinois College of Medicine in 1965 and completed his internship at Milwaukee County General Hospital. He spent two years with the U.S. Public Health Service as medical officer-in-charge at an Indian reservation in Alaska, and at the same time he served as a flight officer with the Coast Guard. Doctor Bonaldi did a three-year residency at the University of Iowa before joining the Riverwood Clinic. Doctor Kim graduated from the College of Liberal Arts and Science of Seoul National University where he also received his medical degree from the College of Medicine. Doctor Kim served his internship at Grosse Point Hospital in Michigan and completed his residency training at the University of Chicago Hospital and Clinic.

Larry R. Lantis, MD

. . . Madison, recently joined the practice of MDs Garrett Cooper* and Thomas Kemp,* Madison. Doctor Lantis graduated from the University of Iowa Medical School and served his internship at Philadelphia General Hospital. His residency training was completed at the hospital of the University of Pennsylvania.

Louis H. Frase, MD

. . . Eau Claire, has joined the staff of the Midelfort Clinic, Eau Claire. He graduated from the University of Illinois Medical School and interned at St. Elizabeth Hospital, Youngstown, Ohio. He served a two-year residency at St. Elizabeth Hospital and a one-year fellowship at the University of Cincinnati. Doctor Frase recently completed two years with the United States Army.

William M. Hinz, MD

. . . Green Bay, recently joined the staff of the West side Clinic. A graduate of George Washington University Medical School, he took his residency at the U.S. Naval Hospital, Portsmouth, Va., and was awarded a fellowship for the study of pediatric infectious disease at the University of Oklahoma Medical Center. He also served a year in Vietnam and two years at the U.S. Naval Hospital, Bremerton, Wash.

Jack F. March, MD*
Louis W. Sennett, MD*

. . . Algoma and Milwaukee, respectively, recently were granted fellowships in the American College of Cardiology, the College's highest membership classification.

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Dr. E. J. Nordby Addresses 11th Councilor District

E. J. Nordby, MD* of Madison, chairman of the State Medical Society's Council, was the dinner speaker for the Society's Eleventh Councilor District meeting September 8 on Madeline Island near Superior.

His topic was "Medical Thoughts," a review of current affairs within the State Medical Society and the American Medical Association.

District members attending from Superior, Ashland, Bayfield, Washburn, Hurley, and Iron River elected J. M. Jauquet, MD* of Ashland as president succeeding R. R. Mataczynski, MD* of Superior. R. A. Stanley, MD* of Ashland is the new secretary-treasurer.

Special guests attending in addition to Dr. Nordby were Dale V. Moen, MD* and Mrs. Moen, Shell Lake, past president of the Woman's Auxiliary to the State Medical Society, and Earl R. Thayer, Madison, secretary of the State Medical Society.

Arrangements for the meeting, which included tennis, golfing, pheasant and duck hunting and tours of the island, were made by the district councilor, Thomas J. Doyle, MD* of Superior.

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF SEPTEMBER 1971

2 Advisory Committee on Utilization Review Programs
2 Advisory Group and Committees, Wisconsin Regional Medical Program
2 Conference on the Physician's Assistant
2 Madison and Area Otolaryngologists Seminar
7 Dane County Medical Society Board of Trustees
8 Board of Directors, Wisconsin Regional Medical Program
8 Finance Committee of SMS Annual Meeting
9 SMS Commission on Hospital Relations and Medical Education with Ad Hoc Joint Practice Committee of Wisconsin Nurses Association
9 Ninth Councilor District, Wisconsin State Dental Society
11 Ad Hoc Committee on SMS Annual Meeting
11 Leadership Training Seminar, Wisconsin Chapter of American Association of Medical Assistants
12 Executive Board, Wisconsin Chapter of American Association of Medical Assistants
15 Board of Trustees, SMS Realty Corporation
16 Executive Committee, SMS Commission on Medical Care Plans
18 Executive Committee of SMS Council
18 Wisconsin College Health Association
19 SMS Division on Nervous and Mental Diseases
19 SMS Commission on Safe Transportation
22 SMS Commission on State Departments
22 SMS Committee on Economic Medicine
23 Madison Academy of Internal Medicine
23 SMS Commission on Scientific Medicine
28 State Pharmacy Board Examinations
28 Board of Directors, Wisconsin Association of Professions
30 Executive Committee of PACE
30 Conference on Fetal–Perinatal Medicine
30 SMS Commission on Public Policy

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Waukesha Memorial Names New Medical Education Director

Albert J. Motzel, MD* of Waukesha has been appointed Director of Medical Education at Waukesha Memorial Hospital. He will assume his new duties on November 15.

Dr. Motzel's primary responsibility will be working with the medical staff divisional and departmental chiefs in developing on-going educational and scientific programs for members of the hospital's medical staff.

In addition, Dr. Motzel will coordinate physicians' activities as they relate to the hospital's on-going and other educational activities. He will work with the hospital in developing further community educational activities and will assist in developing liaison with the two medical schools located in the state as well as the other schools offering educational programs for paramedical personnel.

Although Dr. Motzel expects to devote 20 to 25 hours per week to his new position, he also will maintain a private practice in the field of general surgery on a part-time basis.

New Radiotherapy System at UW

The first minicomputer-controlled radiotherapy system now is treating patients on a day-to-day basis with a 20–30 percent reduction in setup time at the University of Wisconsin Hospitals. The new system is called CART (Computer-Assisted Radiation Therapy).

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UW Medical Librarian Retires

As librarian, historian, collector, and a musician, Assistant Professor Helen Crawford will long be remembered for her contributions to the Middleton Medical Library and the University of Wisconsin Center for Health Sciences.

This summer Professor Crawford retired as librarian and director of the Library, a position she had held for 26 years.

Peter L. Eichman, MD,* dean of the Medical School, reflected the feeling of many of her colleagues and thousands of former students in the health field when he said, "The library will forever have a character which reflects Miss Crawford's thoroughness and persistent devotion to excellence."

Since 1945 when she came to Wisconsin from Iowa State University at Ames, Miss Crawford has expanded library services and tripled the size of the collection. To Van R. Potter, PhD assistant director of McArdle Laboratory for Cancer Research and former chairman of the library committee, "Miss Crawford epitomizes the concept of personalized service—to medical center faculty, to the Library, and to the University."

Miss Crawford

Her belief is that libraries are meant to be used and not stand as repositories for otherwise unwanted volumes, no matter how valuable. Thus, she has expanded the statewide library service so that all volumes in the Middleton Medical Library are available to lay people as well as physicians and hospitals throughout Wisconsin.

To Professor Crawford, however, the highlight of her career was completion of the new Middleton Medical Library in 1966. Built chiefly with funds donated by Wisconsin Medical School Alumni Association members and friends of the Medical School, the Library was the fulfillment of many plans and dreams. With the architects she designed a building that is useful to faculty and students as well as one easily managed by the library staff.

With all that space in the new building, Miss Crawford could begin expanding specialty sections in earnest. Of prime interest to her was the history of medicine collection. A collector at heart, she has added old, but very useful, anatomy, physiology, and neurology editions from the 18th and 19th centuries to the Middleton stacks, making it one of the finest, most extensive history of medicine collections in an American medical school.

Many of the volumes in this special collection were acquired in 1969 by Miss Crawford at a rare book auction in London. The books were being sold by the Royal Medical Society of Edinburgh Library, which was founded in 1734.

Miss Crawford's plans for retirement are as ambitious as ever. She is vice president and president-elect of the Medical Library Association and is a consultant to the new medical school library at Texas Tech University in Lubbock. She moved to Texas in September for about a year.

Miss Virginia Holtz succeeds Miss Crawford as director of the Middleton Medical Library.

Art–Handicraft Show to Be Featured at Society's 1972 Annual Convention

The Woman's Auxiliary is planning an expanded art show for the State Medical Society's 1972 Annual Meeting in Milwaukee.

The Medical Art Salon, now in its eleventh year, will feature many forms of handicraft done by physicians and their wives, it was announced by Mrs. D. G. MacMillan of Barron, president of the Auxiliary.

Many categories will include original sculpture, metals, ceramics, needlework, woodworking, and wood carving as well as oils, pastels, watercolors, etchings, acrylics, pen and ink drawings, and a variety of crafts.

Entry forms will be published in a future issue of the WMJ along with rules for entries to the contest.

Mrs. MacMillan explained that the purpose of this expanded show is to display the many forms of hobby-craft by physicians and their wives and to create an incentive for others to begin some form of art.

Annual Meeting Dates in Limbo

At this printing, the State Medical Society's Annual Meeting dates for 1972 are in limbo. Conflicting programs at the Milwaukee Auditorium have created the dilemma which is currently being thrashed out in numerous conferences.

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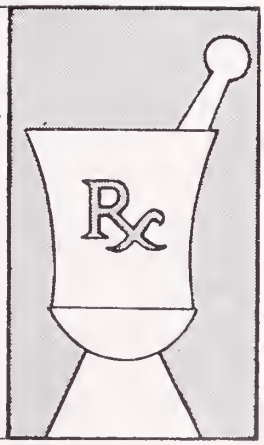

MCW and St. Luke's Hosp. Agree to Joint Programs

The Medical College of Wisconsin and St. Luke's Hospital, both of Milwaukee, recently announced that they have concluded an affiliation agreement for the conduct of joint programs of health education, research, and service to patients.

Gerald A. Kerrigan, MD,* dean and vice-president of the Medical College, and Merton E. Knisely, president of St. Luke's, jointly announced the agreement approved by the boards of directors of both institutions.

The two men explained that the affiliation concerns programs in thoracic and cardiovascular surgery, cardiology, physical medicine, otolaryngology, psychiatry, and preventive medicine.

CONTRIBUTIONS—CES FOUNDATION

August 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for August 1971:

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Museum of Medical Progress—Tuberculosis Exhibit

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Dr. Weygandt Elected V-C Council on Highway Safety

James L. Weygandt, MD* of Sheboygan Falls in September was elected vice-chairman of the Governor's Advisory Council on Highway Safety. He has been a member of the Council since 1968.

In addition to being chairman of the State Medical Society's Commission on Safe Transportation, Doctor Weygandt is secretary of the American Association of Automotive Medicine, member of the National Safety Council's Committee on Alcohol and Drugs, and was a member of the Special 1967 Subcommittee on Alcohol and Drugs to the President's Committee for Highway Safety.

A graduate of the College of Wooster, Ohio, and Western Reserve School of Medicine, Cleveland, Doctor Weygandt served in the Pacific Theater with the U. S. Navy during World War II. He has been a general practitioner in Sheboygan Falls since 1955.

Oops! "Miss Wisconsin Student Nurse" Is a Mr.

Wisconsin's student nurse of the year for 1971 refused to wear the traditional crown worn by past winners. It would look out of place with his trim moustache, he observed.

Dwight D. Schafer, a young veteran attending college under the G.I. Bill in Oshkosh, captured the title from eight competing female contestants, causing the sponsors, the Wisconsin Student Nurses Association to change it from "Miss Wisconsin Student Nurse," to "Student Nurse of the Year."

Schafer, 25, has two semesters to go before he receives a bachelor of science degree in nursing. He plans a career in nursing, perhaps in the public health field.

He spent four years in the Navy as a corpsman, including one year in Vietnam with the First Marine Division, and was discharged three years ago as a hospital corpsman.

The veteran is one of about eight male students in a class of 65. □

OBITUARIES

James C. Fox, MD, 64, a former chairman of the State Medical Society's Council and a founder of the La Crosse Clinic, died June 12, 1971, in La Crosse.

Doctor Fox was widely known as a medical, civic, and religious leader, although modest and humble in all of his endeavors. A practicing internist, Doctor Fox dedicated his life to the cause of high quality medical care.

For 21 years Doctor Fox was a member of the Society's Council and served as its chairman from 1959 to 1968. At the time of his death he was a member of the Society's Commission on Medical Care Plans which directs the health insurance program, Wisconsin Physicians Service. He also was an alternate delegate to the American Medical Association.

Born Nov. 23, 1906, in Shullsburg, Doctor Fox graduated as valedictorian from the Shullsburg High School. He then spent two years attending Loras College in Dubuque, Iowa. From there he went to Marquette University School of Medicine in Milwaukee. Because of Marquette's building program he transferred for his final year to Loyola University in Chicago where he received his medical degree in 1932.

Doctor Fox served his internship at Cook County Hospital in Chicago and his residencies at Mercy and Lewis Memorial hospitals in Chicago. Further postgraduate work in internal medicine was taken at Harvard Medical School, Massachusetts General Hospital, and Peter Bent Brigham Hospital in Boston.

After completing his various residency programs, Doctor Fox joined the U.S. Army and became assistant to the medical director of the Sixth Corps Area whose headquarters were in Sparta. In this position he traveled to the various CCC camps reviewing the medical facilities. It was during this time that he met his wife, the former Harriet Beckman of Sparta.

Returning to civilian life in 1938, Doctor Fox established a private practice in La Crosse; he later became associated with Doctors James E. McLoone and Joseph Egan. Following the death of Doctor McLoone Doctors Fox and Egan formed a partnership which led to the establishment of the La Crosse Clinic in 1948, soon to be joined by Doctors B. Mansheim and G. Uhrich.

Doctor Fox took a sabbatical leave in 1954–1955 to complete certification requirements for the Board of Internal Medicine at the Lahey Clinic in Boston.

For many years Doctor Fox was chief of internal medicine at St. Francis Hospital in La Crosse and medical director of St. Michael's Orphanage. Throughout the years Doctor Fox served voluntarily in various community health activities. He was physician for Viterbo College, Holy Cross Seminary, and was on the advisory board to Children's Service Society, Boy Scouts, National Foundation for Infantile Paralysis, La Crosse Health Council, Wisconsin Heart Association, and president of the Catholic Physicians Guild, and vice-president of the Association of Railway Physicians and Surgeons.

He enjoyed teaching the student nurses when St. Francis Hospital had a nursing school and was one of its favorite commencement speakers. Among his attributes was his continual effort to stimulate good relationships between the hospitals and between individual physicians in La Crosse.

In 1969 Doctor Fox was honored by the Pope when he was knighted in the Order of the Holy Sepulcher of Jerusalem by John Cardinal Carberry, archbishop of St. Louis, for his service to the Catholic Church. He was the first physician to be so knighted by the Order. Records show that only one other doctor from the State of Wisconsin has ever been knighted to date.

A truly dedicated man of medicine, Doctor Fox spent his entire career paving the way for a greater understanding by the community for the value of an ethical physician. But Doctor Fox had other enrichments of life, too: he loved to "sing," he loved the birds, he loved his home and his family.

Doctor Fox was a member of the La Crosse County Medical Society, State Medical Society of Wisconsin, American Medical Association, Wisconsin Society of Internal Medicine, International Congress of Cardiology, and the World Medical Association.

Surviving are his widow, Harriet; one daughter, Mrs. Patricia Ann Fleming of Glenview, Ill.; and two sons, Michael J. Fox of Madison and John C. Fox of La Crosse.

Jose C. Prieto, MD, 50, Milwaukee, died June 25, 1971, in Milwaukee.

Born on Dec. 14, 1920, in Havana, Cuba, Doctor Prieto graduated from Havana University School of Medicine in 1944. He took his internship and residency at Mercy Hospital, Des Moines, Iowa. He was in practice at the Veterans Administration Hospital, Wood, and also was an instructor at the Medical College of Wisconsin.

Surviving are his widow, Augustina; and three children, Rafael, Maria, and Jose, Milwaukee.

Otto A. Dittmer, MD, 56, Ripon physician for 21 years, died July 2, 1971, in Ripon.

Born on Sept. 10, 1914, in Milwaukee, Doctor Dittmer graduated from Marquette University School of Medicine, Milwaukee, in 1943 and served his internship and residency at Madison General Hospital, Madison. He was a captain in World War II and served in Germany. Doctor Dittmer was president of the medical staff at Ripon Memorial Hospital and had been a member of the Division on Nervous and Mental Diseases of the State Medical Society of Wisconsin since 1962.

Dr. James C. Fox

Continuing health problems had slowed down Dr. James C. Fox somewhat the past few years.

But nothing could lessen his devotion to his patients and his community. He was still working, and planning for the future, right up to his death last week.

His stature as a physician is too well known after his 35 years in La Crosse to need any detailed listing here: founder of the La Crosse Clinic, director of the state medical society for two decades, chief of internal medicine at St. Francis Hospital.

Jim Fox's civic involvement was equally broad. If it helped people, he was there and likely to be carrying more than his share of the load.

He treated his patients on a first-name basis, and his personal concern must have made many an illness seem less formidable.

The friends and associates of James Fox, and the entire community, have suffered a loss by his early passing.

(*La Crosse Tribune*, June 14, 1971)

He was also a member of the Fond du Lac County Medical Society and the American Medical Association.

Surviving are his widow, Betty; and two sons, James and Robert, Ripon.

Charles Phillip Giesen, MD, 50, Tomah, died July 12, 1971, in Tomah.

Born on Aug. 13, 1920, in Superior, Doctor Giesen graduated from Temple University Medical School in 1945 and served his internship and residency at Milwaukee County General Hospital. Doctor Giesen was a captain in the United States Medical Corps from 1946–1948 and had been affiliated with the Tomah Veterans Administration Hospital since 1954.

Surviving are his widow, Esther; and two sons, Charles W. and James, both of Madison.

Homer M. Buckner, MD, 85, Dodgeville, died Aug. 5, 1971, in Dodgeville.

Born on July 10, 1886, in Clark County, Ill., Doctor Buckner graduated from Loyola University School of Medicine in 1914 and served his internship at Madison General Hospital, Madison. He had previously practiced in Prairie du Sac, Mt. Horeb, and moved to the Dodgeville area in 1940.

He was a member of the Iowa County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving is his widow, Arline.

Karl K. Amundson, MD, 81, Cambridge physician for more than 50 years, died Aug. 10, 1971, in Ft. Atkinson.

Born on Feb. 27, 1890, in Cambridge, Doctor Amundson graduated from the Medico-Chirurgical College of University of Pennsylvania and served his internship at Milwaukee Hospital.

He was a member of the 50-Year Club of the State Medical Society of Wisconsin, a member of the Dane County Medical Society and American Medical Association.

Surviving are his widow and two children.

Kenneth Cody Case, MD, 32, Cleveland, Ohio, a former physician and psychiatrist at Mendota State Hospital, Madison, died Aug. 24, 1971, in Madison.

Born on April 23, 1939, in Beloit, Doctor Case graduated from the University of Illinois College of Medicine in 1968 and interned at St. Luke's Hospital in Milwaukee.

Surviving are his widow and a daughter, Madison.

Frank R. Menne, MD, 83, Peebles, a noted pathologist in cancer research, died Aug. 25, 1971, in Fond du Lac.

Born on Mar. 20, 1888, in Fond du Lac County, he graduated from Rush Medical College, Chicago, in 1915. He was appointed assistant professor of pathology at the University of Oregon Medical School, Portland, in 1916. He later became head of the Pathology Department at Oregon Medical School and resigned in 1944. Doctor Menne served as senior consultant and part-time director of laboratories at the Veterans Hospital, Portland, from 1922–1958. He also served as a consultant in criminology throughout the Pacific Northwest, including Alaska. He retired in April 1958 when he moved to Peebles, near Fond du Lac.

Doctor Menne was the originator and first president of Pacific Northwest Society of Pathologists, a member of the American Medical Association, State of Oregon Medical Society, and the American Society of Clinical Pathologists. He also was a member of the American Board of Pathology, and a fellow of American College of Physicians.

Surviving are his widow, Viola, and a daughter, Mrs. John Nett of the Town of Empire, Fond du Lac County, Wisconsin. □

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Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

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Contraindications Pregnancy (may virilize female fetus), mammary carcinoma in the male, prostatic carcinoma, severe liver disease, severe cardiorenal disease and severe persistent hypercalcemia.
Precautions Employ with caution in young boys to avoid precocious sexual development and premature epiphyseal closure. Androgens tend to promote retention of sodium and water, therefore, watch for edema—particularly in the elderly. Incidence and severity of edema have been minimal and have been associated only with high doses used for palliation of breast cancer. Hypercalcemia may occur, particularly in patients with metastatic breast carcinoma; if this occurs the drug should be discontinued. Changes in liver function tests, such as increased BSP retention and SGOT levels, can occur during therapy. Jaundice has been rarely reported. If liver function tests are altered, discontinue medication or reduce dose. Priapism is indicative of excessive dosage and is indication for temporary withdrawal of drug. When treating protein depletion states or osteoporosis, an adequate diet should be provided and prolonged immobilization avoided whenever possible. When treating aplastic or hypoplastic anemias, androgen therapy should not replace other measure such as transfusion, correction of iron deficiency, antibacterial therapy, and the use of corticosteroids.
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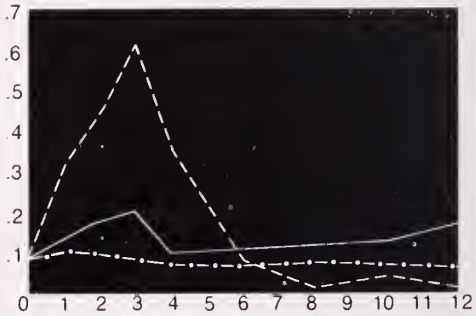

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MEDICAL MEETINGS
POSTGRADUATE COURSES

This listing is compiled by the State Medical Society of Wisconsin in cooperation with others who wish to maintain a centralized schedule of meetings and courses of interest to Wisconsin physicians and to avoid scheduling programs in conflict with others. Copy for this listing should reach the Journal office by the tenth of the month preceding the month of publication.

1971 WISCONSIN

Dec. 2: Third annual Parkview Medical Associates Clinical Symposium on Sports Injuries, Hartford High School Auditorium, Hartford.

1971 NEIGHBORING STATES

Nov. 26–27: Conference on Radiology in Otolaryngology and Ophthalmology, Abraham Lincoln School of Medicine, Chicago, Ill.

Dec. 3: Cardiac and Respiratory Disease Conference, University of Iowa College of Medicine, Iowa City.

Dec. 4–9: Annual Meeting, American Academy of Dermatology, Palmer House, Chicago, Ill.

Dec. 8–9: Obstetrics and Gynecology Conference, University of Iowa College of Medicine, Iowa City.

Dec. 10–11: Continuing Education Program in Surgery, University of Iowa College of Medicine, Iowa City.

1971 AMA

Nov. 28–Dec. 1: AMA Clinical Session, New Orleans, La.

1972 WISCONSIN

Jan. 9: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "The First 60 Minutes After Pulmonary Embolus" and "Selection and Plan for Anticoagulant Therapy," at St. Marys Hospital Medical Center, Madison.

Feb. 17: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Immediate Care of Acute Stroke" and "Current Management of Diabetic Keto-acidosis and Coma," at St. Marys Hospital Medical Center, Madison.

Feb. 18–19: Annual Meeting, Wisconsin Otolaryngological Society, SMS Building, Madison.

Mar. 15: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Current Management of Rh ve Pregnant Patient Before and After Delivery" and "Current Management of the Newborn Who Becomes Jaundiced in the First 24 Hours," at St. Marys Hospital Medical Center, Madison.

Mar. 23–25: *Learning Disabilities in Children,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Mar. 31–Apr. 1: Midwest Chapter, College of Sports Medicine Meeting, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 13–15: *Advances in Pediatric Radiology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–12: *Genetics for the Clinician,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Jan. 23–29: *Concepts of Soft Tissue Surgery,* Mercy Hospital, Pittsburgh, Pa., sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $400. Contact: John T. Dickinson, MD, DSc, G-2 MD Bldg., 1501 Locust St., Pittsburgh, Pa. 15219.

Feb. 5–12: Annual scientific meeting, Far Western Medical Association, Aspen, Colo. Info: A. J. Krukas, MD, Secretary–Treasurer, Suite 416, 16542 Ventura Blvd., Encino, Calif. 91316.

Feb. 6–11: *Rhinoplasty Workshop in Toronto,* University of Toronto Department of Post Graduate Medicine, Department of Otolaryngology, Department of Anatomy, Division of Instructional Media, sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $300, residents—$150. Contact: Mrs. Caroline Flynn, Division of Post Graduate Medicine, U. of Toronto, Toronto, Ontario, Canada.

Feb. 21–23: Scientific Sessions Seminar, Ala Moana Hotel, Honolulu, Hawaii. Info: Scientific Sessions, 217 Alexander St., Rochester, N. Y. 14607.

Feb. 23–26: *Surgery of the Hand,* University of Colorado School of Medicine, Denver.

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Feb. 27–Mar. 3: *Workshop in Advanced Rhinoplasty,* Department of Otolaryngology, Baylor University College of Medicine, Houston, Tex., sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $500. Contact: Dr. William K. Wright, Director, Suite 508 Hermann Professional Bldg., Texas Medical Center, Houston, Tex. 77025.

Feb. 28–Mar. 2: *Modern Concepts in Acute and Chronic Cardiopulmonary Care—Newborn, Adult,* American College of Chest Physicians and others, Steamboat Springs, Colo.

Feb. 28–Mar. 3: Winter meeting, American Society of Contemporary Ophthalmology, Diplomat Hotel, Hollywood, Fla. Info: John G. Bellows, MD, Secretary, 30 North Michigan Ave., Chicago, Ill. 60602; tel. 312/236–4673.

Mar. 13–16: *Maxillofacial Trauma,* Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center, Cincinnati, Ohio, sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Tuition: $400. Registrar: Miss Debby Adkins, Office of CONMED, Room 114, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

April 21: Symposium on Infectious Diseases, American Academy of General Practice, Battenfeld Auditorium, Kansas City, Kan.

Apr. 23–29: Ninth Interamerican Congress of Cardiology, San Francisco, Calif.

May 12–13: Clinical–Professional Meeting, American College of Legal Medicine, Americana Hotel, Miami Beach, Fla. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

Sept. 25–28: Annual scientific assembly, American Academy of General Practice, New York Coliseum, New York, N.Y.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Biltmore Hotel, Los Angeles, Calif. Info: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New York N.Y. 10017.

1972 INTERNATIONAL

Mar. 4–11: Scientific meeting, Far Western Medical Association, Zermatt, Switzerland, followed by a week at Val D'Isere, France. Info: A. J. Krukas, MD, Secretary–Treasurer, Suite 416, 16542 Ventura Blvd., Encino, Calif. 91316.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1974 INTERNATIONAL

Oct. 20–26: XIth International Cancer Congress, Florence, Italy.

For listing of other meetings see the **Journal of the American Medical Association.**

Symposium on Sports Injuries—Hartford

The third annual Parkview Medical Associates Clinical Symposium on Sports Injuries will be held Thursday, December 2, at the high school auditorium in Hartford.

There will be a panel discussion devoted to musculoskeletal injuries in high school athletes. The program is aimed at aiding physicians, coaches, and trainers who are responsible for preventing and treating these injuries and getting the athlete back to competition.

The program will start at 7:30 pm; no registration, and all interested persons are welcome.

In-Depth Teaching Program—Madison

The second in-depth teaching program of the State Medical Society and University of Wisconsin Medical Center will be presented December 9 in Madison at St. Mary's Hospital Medical Center.

Group ward rounds and demonstrations will be conducted in the morning, followed by a luncheon, and an afternoon of lectures and discussions.

George G. Rowe, MD, professor of medicine, will lecture on "Management of Angina Pectoris." James H. Thomsen, MD, assistant professor of medicine, will discuss "When and Whom to Refer for Coronary Angiography."

Participation has already been arranged through preregistration.

This program is one in a series of five. Other remaining programs are scheduled for January 19, February 17, and March 15. Details appeared in the October issue.

Refresher Course for Family Physicians—Milwaukee

The Medical College of Wisconsin will hold the Second Annual Winter Refresher Course for Family Physicians January 27–30 at the Pfister Hotel and Tower in Milwaukee.

continued on page 10

Pre-Sate® (chlorphentermine hydrochloride)

Caution: Federal law prohibits dispensing without prescription.

Indications
Pre-Sate (chlorphentermine hydrochloride) is indicated in exogenous obesity, as a short term (i.e. several weeks) adjunct in a regimen of weight reduction based upon caloric restriction.

Contraindications
Glaucoma, hyperthyroidism, pheochromocytoma, hypersensitivity to sympathomimetic amines, and agitated states. Pre-Sate (chlorphentermine hydrochloride) is also contraindicated in patients with a history of drug abuse or symptomatic cardiovascular disease of the following types: advanced arteriosclerosis, severe coronary artery disease, moderate to severe hypertension, or cardiac conduction abnormalities with danger of arrhythmias. The drug is also contraindicated during or within 14 days following administration of monamine oxidase inhibitors, since hypertensive crises may result.

Warnings
When weight loss is unsatisfactory the recommended dosage should not be increased in an attempt to obtain increased anorexigenic effect, discontinue the drug. Tolerance to the anorectic effect may develop. Drowsiness or stimulation may occur and may impair ability to engage in potentially hazardous activities such as operating machinery, driving a motor vehicle, or performing tasks requiring precision work or critical judgment. Therefore, such patients should be cautioned accordingly. Caution must be exercised if Pre-Sate (chlorphentermine hydrochloride) is used concomitantly with other central nervous system stimulants. There have been reports of pulmonary hypertension in patients who received related drugs.
Drug Dependence Drugs of this type have a potential for abuse. Patients have been known to increase the intake of drugs of this type to many times the dosages recommended. In long-term controlled studies with the high dosages of Pre-Sate, abrupt cessation did not result in symptoms of withdrawal.
Usage In Pregnancy The safety of Pre-Sate (chlorphentermine hydrochloride) in human pregnancy has not yet been clearly established. The use of anorectic agents by women who are or who may become pregnant, and especially those in the first trimester of pregnancy, requires that the potential benefit be weighed against the possible hazard to mother and child. Use of the drug during lactation is not recommended. Mammalian reproductive and teratogenic studies with high multiples of the human dose have been negative.
Usage In Children Not recommended for use in children under 12 years of age.

Precautions
In patients with diabetes mellitus there may be alteration of insulin requirements due to dietary restrictions and weight loss. Pre-Sate (chlorphentermine hydrochloride) should be used with caution when obesity complicates the management of patients with mild to moderate cardiovascular disease or diabetes mellitus, and only when dietary restriction alone has been unsuccessful in achieving desired weight reduction. In prescribing this drug for obese patients in whom it is undesirable to introduce CNS stimulation or pressor effect, the physician should be alert to the individual who may be overly sensitive to this drug. Psychologic disturbances have been reported in patients who concomitantly receive an anorectic agent and a restrictive dietary regimen.

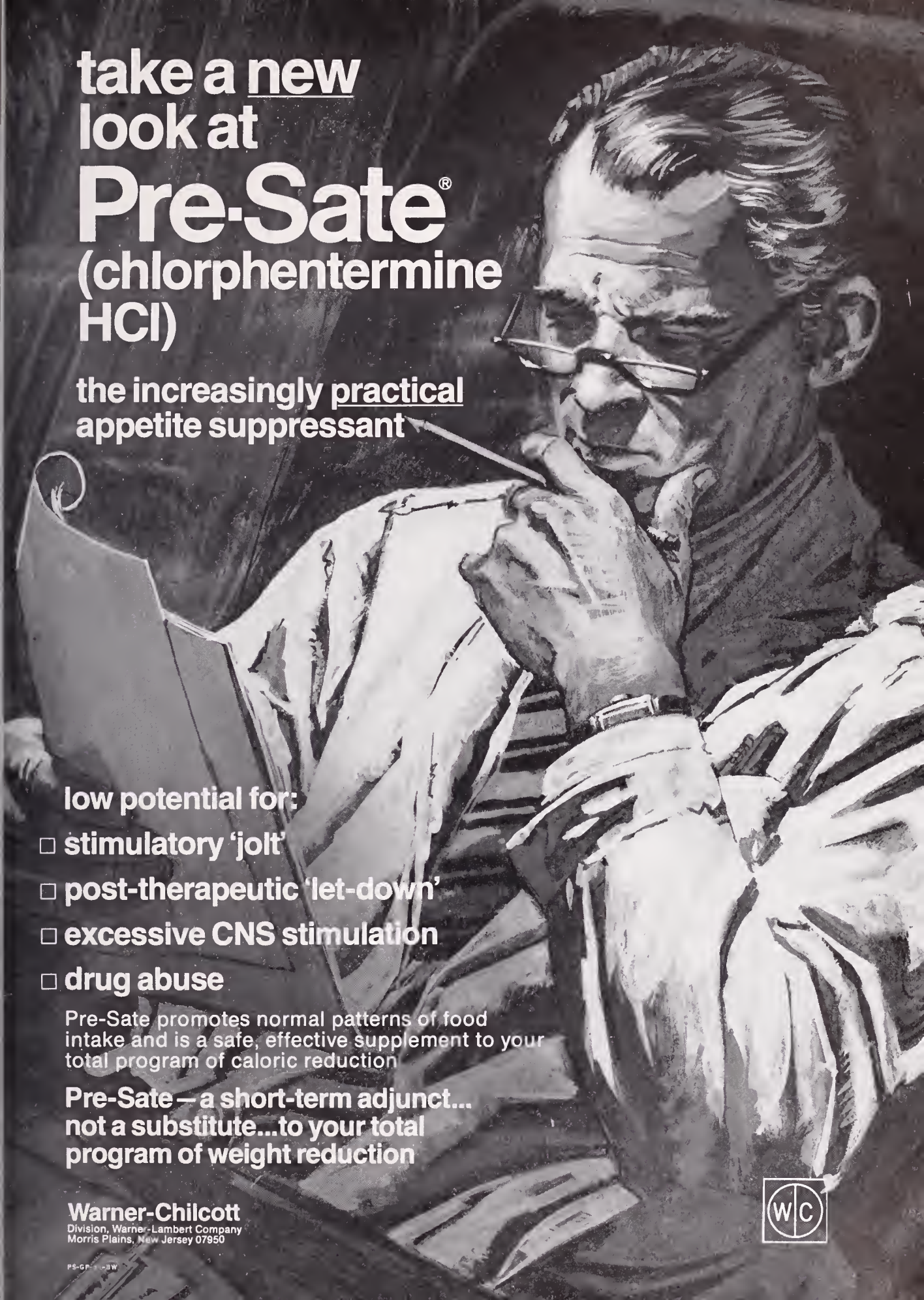
Adverse Reactions
Central Nervous System: When CNS side effects occur, they are most often manifested as drowsiness or sedation or overstimulation and restlessness. Insomnia, dizziness, headache, euphoria, dysphoria, and tremor may also occur. Psychotic episodes, although rare, have been noted even at recommended doses. **Cardiovascular:** tachycardia, palpitation, elevation of blood pressure. **Gastrointestinal:** nausea and vomiting, diarrhea, unpleasant taste, constipation. **Endocrine:** changes in libido, impotence. **Autonomic:** dryness of mouth, sweating, mydriasis. **Allergic:** urticaria. **Genitourinary:** diuresis and, rarely, difficulty in initiating micturition. **Others:** Paresthesias, sural spasms.

Dosage and Administration
The recommended adult daily dose of Pre-Sate (chlorphentermine hydrochloride) is one tablet (equivalent to 65 mg chlorphentermine base) taken after the first meal of the day. Use in children under 12 not recommended.

Overdosage
Manifestations: Restlessness, confusion, assaultiveness, hallucinations, panic states, and hyperpyrexia may be manifestations of acute intoxication with anorectic agents. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension, or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Fatal poisoning usually terminates in convulsions and coma.
Management: Management of acute intoxication with sympathomimetic amines is largely symptomatic and supportive and often includes sedation with a barbiturate. If hypertension is marked, the use of a nitrate or rapidly acting alpha-receptor blocking agent should be considered. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendations in this regard.

How Supplied
Each Pre-Sate (chlorphentermine hydrochloride) tablet contains the equivalent of 65 mg chlorphentermine base; bottles of 100 and 1000 tablets.

Full information is available on request.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The four-day course, cosponsored by the Wisconsin Academy of Family Physicians and its Milwaukee chapter, will include review and discussion of medical topics of particular interest to family physicians and a practice exam for doctors intending to take the family practice board examination.

Lawrence V. Perlman, MD, Assistant Professor of Medicine at MCW and the course director for the sessions, will be assisted by other members of the MCW faculty in presenting the topics. Evening sessions will feature a "Meet the Professor" format, with cases presented by fellows or residents in the various areas for discussion by the professor with participants.

The course is approved for 24 hours of prescribed credit by the American Academy of Family Physicians.

Registration is limited to 100 participants and will close on December 15. For further information on registration and tuition, and for a copy of the program, contact Mrs. Elaine Gamerdinger, Continuing Education Department, Medical College of Wisconsin, 561 North 15th Street, Milwaukee, Wis. 53233.

Continuing Education Conferences—Iowa

Continuing education conferences on cardiac and respiratory disesase and on obstetrics and gynecology will be held at The University of Iowa Health Center in December.

The cardiac and respiratory disease conference will be held on Friday, December 3, with the morning session devoted to cardiac problems and the afternoon session dealing with respiratory disease.

Among topics at the cardiac session will be therapeutic implications of the autonomic control of the heart in myocardial infarction, heart block—new concepts clarify a confusing clinical problem, evaluation of the hypertensive patient, and discussion of problem cases.

The obstetrics and gynecology conference will be held Wednesday and Thursday, December 8–9. Among topics at the conference will be methods of determining fetal maturity, the hazards of breach delivery, the value of a high risk prenatal clinic, management of ovarian carcinoma.

Continuing Education Program in Surgery—Iowa

A continuing education program in surgery will be held at The University of Iowa Health Center on Friday and Saturday, December 10 and 11.

Among discussion topics will be use of homografts and xenografts in burns and other surgical conditions, the importance of glucose in intravenous fluids, surgical problems of the umbilicus in infants and children, and new concepts in diagnosis and treatment of breast cancer.

On Saturday, registrants will be invited to attend surgical grand rounds and clinical conferences at the U of I Hospitals. Among conferences will be hemodialysis, renal disease, neuropathology, neurology–neurosurgery, urology–radiology, hypertension, and orthopedics.

Far Western Medical Association

Far Western Medical Association has scheduled its annual scientific meeting at Aspen, Colo., for the week of February 5–12, 1972, according to R. A. Ullrich, MD, president. Convention headquarters will be the Aspen Alps Club.

Non-members also may attend the meeting, and can obtain advance registration forms and a schedule of the week's activities by writing to A. J. Krukas, MD, secretary–treasurer, Suite 416, 16542 Ventura Blvd., Encino, Calif. 91316.

A second scientific meeting of the FWMA is scheduled for a week at Zermatt, Switzerland, beginning March 4, 1972, followed by a week at Val D'Isere, France.

Surgery of the Hand—Colorado

A four-day postgraduate course on "Surgery of the Hand" will be presented by the University of Colorado School of Medicine in Denver Feb. 23–26, 1972.

The course will consider various aspects of trauma to the hand, reconstructive surgery, nerve transfers, and congenital defects. All physicians with an interest in the subject and level of the course are welcome.

Guest faculty includes: Robert A. Chase, MD, professor and chairman, Department of Surgery, Stanford University School of Medicine, Stanford, Calif.

Raymond M. Curtis, MD, assistant professor of plastic surgery, Johns Hopkins University School of Medicine, and past president of American Society for Surgery of the Hand, Baltimore, Md.;

Milton T. Edgerton, MD, professor and chairman, Department of Plastic Surgery, University of Virginia School of Medicine, Charlottesville, Va.; and

Austin D. Potenza, MD, assistant clinical professor of plastic surgery, State University of New York, Downstate Medical Center, Hempstead, N. Y.; and members of the faculty of the U of C School of Medicine.

Tuition for the four days: $100. Info: Office of Postgraduate Medical Education, U of C School of Medicine, 4200 East Ninth Ave., Denver, Colo. 80220.

Cardiorespiratory Care—Colorado

"Modern Concepts in Acute and Chronic Cardiorespiratory Care—Newborn, Adult," a four-day postgraduate course will be presented in Steamboat Springs, Colo., Feb. 28–Mar. 2, 1972. This program has been developed jointly by the American College of Chest Physicians; Pediatric Cardiopulmonary Department, University of Colorado Medical Center; and the Cystic Fibrosis Foundation. Course directors: Ernest K. Cotton, MD, and Margo Pinney, PHN.

The postgraduate course is being presented in a resort area to create a relaxed and informal atmosphere. Its purpose is to provide physicians with up-to-date information on pulmonary problems in newborn-children and adults. Specifically, the program will present updated diagnostic and therapeutic information in such problems as RDS, reactive airway disease and chronic obstructive problems. Didactic lectures, slides, movies and practical sessions with actual equipment will be used to present the material. Specific subjects to be covered by the faculty include: shock in the newborn, individual audiovisual aids, assisted ventilation in asthma, cystic fibrosis and chronic obstructive airway disease in children and adults, congenital lung disease, oxygen transport, blood gases, resuscitation, intensive care, hospital and home care, as well as inhalation therapy and related equipment. Time has been allotted for small group work and practice sessions.

Registration fee: $100, ACCP members; $125, non-members, $50, residents. For further information contact the Department of Continuing Education, American College of Chest Physicians, 112 East Chestnut Street, Chicago, Ill. 60611; tel. (312) 787–4933. □

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin—Madison

1972

March 23–25	*Learning Disabilities in Children*
March 31–April 1	*Midwest Chapter, College of Sports Medicine Meeting*
April 13–15	*Advances in Pediatric Radiology*
May 11–12	*Genetics for the Clinician*
June 16–17	*North Central Dialysis and Transplant Conference*
June 8–10	*Recent Progress in Hematology*

INFO: Thomas C. Meyer, MD, Chairman, 575 WARF Office Bldg., Madison, Wis. 53705; tel. 608/2623–2850.

WISCONSIN MEDICAL JOURNAL
Vol. 70, No. 11 NOVEMBER 1971

Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

IN SPECIAL SESSION

SMS Delegates Call for New Legislative Approach

Action taken at the Special Session of the House of Delegates in Madison October 23 called for a new approach to comprehensive health planning and employment of physicians by hospitals. During the Special Session four items of pending health care legislation were considered.

Employment of Physicians by Hospitals (AB 1391)

The essential purpose of the bill is to amend the state's fee splitting statute to permit the employment of physicians on salary by hospitals under certain circumstances, without significant limitation as to number or specialty of practitioner. The bill was requested by the Governor, and its intent is supported by the Wisconsin Hospital Association.

The Council, which met just prior to the Special Session, presented the House of Delegates with these alternatives:

1. SUPPORT AB 1391 without change.
2. OPPOSE amendment of the statute.
3. RECOGNIZE that in limited situations and under proper safeguards the employment of physicians by hospitals may be beneficial in providing health care for the people of Wisconsin.

The House supported the Council's recommendation that alternative three be adopted. It states that situations under which physician employment may be allowable "include those of consultation and emergency room coverage in addition to the currently recognized salaried physicians in government hospitals and teaching hospitals attached to a medical school, where neither institution bills the patient for the professional services of the physician. In such circumstances, the interests of both patient and physician would be safeguarded by:

. . . "Requiring that contracts of employment be approved and supervised by the hospital's medical staff and filing the contracts with the State Board of Medical Examiners;

continued on page 28

Assembly Passes Physician Assistant Bill

The State Medical Society's proposal to certify physician assistants (substitute amendment one to Assembly Bill 707) passed the Assembly 99–0 on October 28 and was immediately sent to the Senate.

State Medical Society President George A. Behnke sent a letter to the Assemblymen expressing appreciation for the bill's passage. He noted that "the bill was passed in a form that represents the efforts of many conferences with government and health leaders."

He complimented the Assemblymen on "seizing the opportunity this bill gives Wisconsin to make a real contribution to improved health care."

The bill's passage followed lengthy debate and the defeat of several amendments which would have carved out sections for optometry, pharmacy, and dentistry. The amendments would have, in effect, prohibited a physician from using a physician assistant in performing *any* of the services provided by those licensed or certified in these occupations or professions.

The bill as passed includes an amendment which prohibits a physician assistant from practicing the entire scope of another licensed health-care group. This preserves the intent of the original legislation developed by the Society at the request of the Governor and the Wisconsin Legislative Council.

In the Senate, the State Medical Society supports substitute amendment one to physician assistant Bill 463. The bill has been reported out of the Education Committee with a vote of 5–0 for passage. It is expected that Senate action may be taken when the legislature reconvenes in January.

New Legislative Approach

continued from page 27

. . . "A prohibition against limiting medical staff membership in a hospital only to employed physicians;

. . . "Continuing the prohibition against hospital interference with the manner or mode of the practice of medicine;

. . . "Providing that the responsibility of physician to patient not be altered, particularly with regard to individual professional liability; and

. . . "That employed physicians be granted full rights as employes including the right of collective bargaining with the employer."

Certificate of Need (AB 1104 and Substitute Amendment 1)

As originally submitted to the Legislature, the bill required certificate of need for licensed institutions such as hospitals and nursing homes.

An amendment (Substitute Amendment 1) would require certificate of need for any health care facility whether licensed or not, when capital expenditures of $100,000 or more are contemplated, and for any expansion in scope or type of services regardless of the cost involved. This obviously results in state franchising of all physicians' offices as well as institutional facilities. Substitute Amendment 1 to AB 1104 has been recommended for passage by the Assembly Committee on Health and Social Services and is on the Assembly calendar for action.

It should be noted that federal legislation (H.R. 1, Social Security amendments) proposes certificate of need to be applied to licensed facilities receiving federal funds under Title 18 and Title 19, but its application is limited to situations involving capital expenditures of $100,000 or more.

The Wisconsin Hospital Association and the Wisconsin Council of Homes for the Aging, among others, endorsed Substitute Amendment 1 to this bill at the public hearing. The Society's position, established at the May 1971 meeting of the House of Delegates, has been that all physicians should actively participate in comprehensive health planning, but that certificate of need is not in the best interest of patient care.

The Council presented the House with four alternatives:

1. SUPPORT original bill AB 1104.
2. SUPPORT Substitute Amendment 1 to AB 1104.
3. RECOGNIZE that the voluntary approach to health planning should be employed wherever possible, but that there is a need to provide local health planning agencies with some degree of authority so that they can assert a measure of influence over the adoption and implementation of their recommendations.
4. OPPOSE all state legislation providing for certificate of need.

The House supported the Council's recommendation that alternative three be adopted. It states that "licensed institutions providing inpatient care account for almost 50% of the total health care dollar (nearly 75% for Medicaid and 73% for Medicare) and thus offer the primary area for progress in elimination of duplication and overlapping of facilities and services."

In addition, the House specified that "there should be deleted all bill references to unlicensed private facilities and to all professional services."

The resolution adopted by the delegates states: "The concept of certificate of need for such facilities would be recognized with due regard to the primary responsibility of the local institutional governing board to determine local health needs and the means of meeting them. Under these circumstances, the decision to grant or deny such certificates should be made by the Council on Health of the Department of Health and Social Services. In addition, it is the premise of such a program of planned allocation of health care facilities that there must be adequate provision for access to certified facilities by all qualified physicians and their patients (open staff arrangements)."

Generic Prescribing and Dispensing (AB 206 and Substitute Amendment 1)

The original bill was introduced early in the legislative session by 34 assemblymen and 4 senators to require the prescription and dispensing of all drugs by their generic names. This bill was opposed in part by the Wisconsin Pharmaceutical Association as being too limited.

Early in October, Substitute Amendment 1 to this bill was offered by 11 assemblymen. This version goes far beyond the original, to the point of opening a physician or pharmacist to loss of license for wilful failure to prescribe or dispense by generic name. A drug equivalency review board of seven members (no provision for a practicing physician) would be created in the Department of Health and Social Services to develop a list of brand name drugs, their generic names, and drug equivalents. The list would be distributed to all persons authorized to prescribe drugs and to all pharmacists. Any drug prescribed by its brand name must also include the drug's generic name if that drug is among those on the list prepared by the drug equivalency board. A pharmacist would be permitted to substitute an "equivalent" drug in filling prescriptions, unless the prescriber specifically requests that no substitution be made. The Substitute Amendment 1 is *supported* by the Wisconsin Pharmaceutical Association.

The Council presented the House with four alternatives:

1. SUPPORT original bill AB 206.
2. SUPPORT Substitute Amendment 1 to AB 206.
3. NOT SUPPORT bill as presently written, but propose that the Legislature authorize a properly qualified study committee to conduct a serious analysis of generic name prescribing and dispensing to de-

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MANAGING EDITOR: Earl R. Thayer, Secretary, State Medical Society of Wisconsin.

termine whether and to what extent therapeutic equivalency actually exists, potential cost savings that might be anticipated from generic name prescription and dispensing, and the cost of implementing and enforcing such a program. The findings of the study committee would be reported to the Legislature.

4. OPPOSE the original bill and the substitute amendment to AB 206.

The House supported the Council's recommendation that alternative three be adopted. It states that "such a course of action recognizes the frequency with which proposals for generic prescription and dispensing are being made both in Wisconsin and elsewhere and the implication of such legislation that generic name prescribing might produce economies without loss of therapeutic value. There remain substantial factual questions as to the number of drugs, if any, which truly are therapeutically equivalent, whether in fact generic prescribing and dispensing would result in significant cost reductions, and whether enforcement of such laws requires so drastic a penalty as loss of physician or pharmacist license. Despite well publicized allegations from many sources to the contrary, there is still major scientific controversy on the question of therapeutic equivalency. The Society would propose that no legislation authorizing substitution of so-called equivalent drugs be undertaken until more generally acceptable data are available."

Expanding the Authority of the Department of Health and Social Services to Administer or Contract for Title 19 Medicaid Benefits (AB 1387)

This proposal was presented by Governor Lucey in his special health message to the Legislature on May 18. The Board of Health and Social Services developed a specific proposal but has taken no final position with regard to it. The current bill was drafted by staff members of the State Department of Administration at the request of the Governor. It was introduced by Representative Czerwinski, Milwaukee, on October 5, at the request of Governor Lucey, and referred to the Committee on Health and Social Services of the Assembly.

The bill's principal purpose appears to be to enlarge the authority of the Department of Health and Social Services (DHSS) so that it may contract for the administration of or the payment for services under the Title 19 Medicaid program with any organization or individual which provides or arranges for such services, including "prepaid health care" groups. This might be interpreted to mean proposed organizations of the health maintenance type, prepaid care of the insured type, or direct operation by the Department of health care facilities and services. At the present time the Department believes it does not have authority to contract with experimental programs for the delivery of Title 19 benefits or to pay for such benefits in advance of services provided to the recipient.

The Council presented the House with three alternatives:

1. SUPPORT AB 1387 as proposed.
2. SUPPORT GREATER FLEXIBILITY for the DHSS in contracting for the administration and conduct of Title 19 benefits in Wisconsin, including the concept of insuring these "risks"; assure that this flexibility includes such mechanisms as the health maintenance organization and provides for close and continuing review of such devices as health maintenance organizations since they are highly experimental at this stage.
3. OPPOSE AB 1387.

The House supported the Council's recommendation that alternative two be adopted. It states that "the Society would recommend that procedures and operations of any expanded mechanism for providing Title 19 benefits be reviewed on financial and operational grounds by appropriate agencies of the state government as are currently authorized contractors for Title 19 benefits, including Blue Shield and Blue Cross."

Public Policy Is Focus of Delegates, President

A letter from Wisconsin Governor Patrick J. Lucey started off the October 23 Special Session of the House of Delegates. State Medical Society President George A. Behnke, MD, Kaukauna, opened the session by reading the letter in which Lucey outlined his position on a number of pieces of health legislation. The Governor ended the letter by saying: "I look forward to having the benefit of your ideas, your analysis of the issues and your specific recommendations as to where and how this legislation may need to be amended or otherwise modified in order to best serve the public interest."

In the day's debate a number of physicians attacked political infringement into delivery of health care. Many had misgivings about unnecessary restrictions on the freedom to practice medicine in the way they felt gave patients the most benefit.

Henry Ashe, MD, Woodruff, put Governor Lucey to task for signing into law a bill extending coverage to chiropractors under the Wisconsin Workmen's Compensation Act. He called on the delegates to "retake the responsibility for practicing medicine."

Patricia Stuff, MD, Bonduel, told the delegates to be "objective and take a hard look at ourselves as others see us." She noted that, "in essence, we don't have free enterprise right now."

Warren Williamson, MD, Racine, said that members of his county medical society had talked to their congressional representative and found him most receptive to their viewpoint. Dr. Williamson emphasized that physicians must express their opinions and make consumers recognize their position. He said, "you can't just say no, this is status quo; we won't change. Once you do this, you are proving to them you want to withdraw like a schizo-

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Public Policy Is Focus

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phrenic and are saying that we will not adapt to some of the changes that might possibly be to the benefit not only of the consumer but possibly the provider."

Recommendations Approved

Dr. Behnke made three recommendations which are aimed at increasing the influence of physicians in governmental policy making. These were unanimously approved by the delegates:

ONE. Designate a physician at the state capitol each week while the legislature is in session;

TWO. Urge each county medical society to meet with its local legislators;

THREE. Formulate proposed legislation in the Council and its appropriate committees before each session of the state legislature.

David Carley, chairman of Governor Lucey's Health Planning and Policy Task Force, spoke to the delegates at midday. He commended the State Medical Society for its participation in the Task Force and outlined Task Force objectives and duties.

Policy As Priorities

He said, "The formulation of public policy is at its base an ordering or reordering of priorities. There really is little public policy in the health field because it is not a top priority." He noted that other issues such as the Vietnam war and flights to the moon have occupied more of Americans' time and attention than the needs of health care.

He told the delegates that members of the Task Force "cannot do our task, and we do not want to, without your help. There will be no effective health system in this nation and in this state without physicians and without their counsel and their advice. It will only be effective with your help."

In discussion later in the day, Paul Dudenhoefer, MD, Elm Grove, said he thought that if the State Medical Society and the Wisconsin Hospital Association could agree, together they could influence many of the recommendations made by the Governor's Task Force. He suggested that major health legislation be delayed until the work of the Task Force was completed.

Politics MD's Business

Fred A. Karsten, MD, Horicon, concurred, saying, "We are being asked to solve some problems when we are not sure what the problem is in the state of Wisconsin. Here in Wisconsin, is there a severe problem with emergency rooms? Where do problems exist with construction of facilities? Any legislation should be deferred until this basic information is at hand."

As the meeting ended, State Medical Society secretary Earl Thayer summed up the position in which physicians find themselves by telling the delegates, "If you go away without feeling that politics is your business, then there is little hope for the Society."

He asked the delegates to contact their representatives about the health care legislation, and noted that the "art and science of politics" is vital to the survival of the "art and science of medicine."

Pediatric Nurse Associate Training Program Funded

Wisconsin Regional Medical Program, Inc. has recently funded a training program for nurse–physician teams designed to help alleviate child health manpower problems. The program is designed to extend the registered nurse's knowledge and skills in ambulatory child care and facilitate the working relationship of a pediatrician and nurse as associates on a health-care team. The program will assist physicians as they reorganize their offices and practices to accommodate the nurse associate–pediatrician team.

The first four-month course will begin in the Madison area in March 1972. Subsequent courses will be offered in other areas of Wisconsin, depending upon local interest and needs. The first course will be limited to four teams. Participating physicians may enroll their present office RN, or the persons named below will help physicians recruit a suitable candidate, preferably a local nurse who is likely to stay in the area and be available to work for a number of years.

The nurses will be qualified to function in the same capacity as outlined in the *Guidelines on Short-term Continuing Education Programs for Pediatric Nurse Associates* prepared by the American Nurse Association and the American Academy of Pediatrics in January 1971. The course will include didactic classroom experience and on-the-job clinical training, whenever possible in the participating physician's office. Physicians will receive consultation and assistance in preparing their patients for the introduction of a nurse associate into their practice, in office organization to accommodate a team approach, improved medical records, etc., to promote efficiency.

The course will be evaluated largely on the basis of its impact on the quantity and quality of services delivered in the practice. Before and after comparisons of practice operation will be used whenever possible. The course will be provided jointly by the University of Wisconsin–Extension, Health Sciences Unit, and the University of Wisconsin Medical School. Any pediatrician interested in obtaining more information about the program should write Karen Pridham, RN, MS, Paul Tracey, MD or Ken Reeb, MD, 1552 University Avenue, Madison, Wisconsin 53706 or call 608/262–1170.

Kenneth G. Reeb, MD
Assistant Professor of Pediatrics
University of Wisconsin
Center for Health Sciences

Volunteer Physicians for Viet Nam Needed

Volunteer Physicians for Viet Nam is a program which provides medical expertise to provincial civilian hospitals in that war ravaged country. The American Medical Association administers this program, which is financed by the United States Agency for International Development (USAID). Volunteer physicians serve a 60-day tour of duty in South Viet Nam. Information is available from: AMA Volunteer Physicians for Viet Nam, 535 N. Dearborn St., Chicago, Ill. 60610.

Over 1100 "Team Up" for Society's Work Week

Over 1100 people involved in all phases of health care "teamed up" October 19–22 during the ninth annual Wisconsin Work Week of Health.

"Teaming Up for Better Health" was the theme for the week which included programs on five different topics in four locations. The wide ranging program attracted audiences including school psychiatrists, psychologists, social workers, guidance counselors, nurses, public health personnel, nursing home administrators, insurance and other business executives, members of government, hospital officials, alcoholism counselors, and clergymen.

Crisis Counseling

The opening Work Week program was primarily aimed at informing those who counsel the young. Topics under discussion included venereal disease, teenage parenthood, drug abuse and suicide.

"The woman who takes birth control pills has a 100 percent chance of contracting gonorrhea should she come in contact with an infected man," H. Grant Skinner, MD, said.

The chief of the communicable diseases section of the Wisconsin Division of Health said a woman not taking the pill has about a 40 percent chance of contracting the disease under the same circumstances. He said the pill has this affect because it makes women's secretions more alkaline and thus a better habitat for the disease cells.

VD Pandemic

He linked the pill to what he called the VD pandemic both for this reason and because the pill takes away fear of pregnancy as a deterrant to sexual relations. There has been a 147 percent increase in reported cases of gonorrhea in Wisconsin since 1965.

Dr. Skinner said gonorrhea is becoming more common among people from 15 to 19 and school educational courses are needed to educate teenagers about the problem before they reach this age.

Along with State Medical Society persident George A. Behnke, MD, Dr. Skinner urged support for a state law to allow physicians to treat minors for venereal disease without first receiving prior parental consent. The Society has sponsored such a proposal which is currently awaiting legislative action.

"Physicians want to treat all those with venereal disease, but we need a law which allows the teenagers to come to us without fear of reprisal from their parents," Dr. Behnke said.

Teenage Parenthood

On the same program Mrs. Betty Lenthall, health services supervisor in Alhambra (Calif.) city schools, told about progress in California with educational programs for teenage parents.

She said in some parts of the country pregnant girls are forbidden to attend school and this adds to the risk that they will wind up on welfare.

Since 1968 the state of California has provided funding to school districts for special programs for teenage mothers to prevent the welfare–unemployment–poverty cycle. Today, of 175 such programs in the United States, 71 are in California.

At a "how to" panel on teenage counseling, Darold A. Treffert, MD, superintendent of Winnebago State Hospital, said alcohol is the most serious teenage drug problem.

Alcohol Killing Youth

The chairman of the State Medical Society's Division on Alcoholism and Addiction said alcohol has killed twice as many Wisconsin youths as the Vietnam war in the same length of time

He also said mental illness is a growing threat to youth. He noted that the number of minors at Winnebago State Hospital is now approaching half of all the patients, and this is becoming the ratio nationally.

The "how to" panelists were professionals involved in counseling: Nicholas Owen, MD, a participating physician in Milwaukee's Underground Switchboard; Philip J. Gibeau, PhD, associate director of community services at the Dane County Mental Health Center, Madison; Aaron Starobin, legal counsel for Milwaukee's Underground Switchboard, St. Mary's Hospital Counseling Center and Pathfinders for Runaways; and Nancy Foreman, RN, of the University of Wisconsin Drug Information Center.

Nursing Home Patients

In a program held October 21 at the Milwaukee Area Technical College, nursing home administrators heard specialists on care of the elderly discuss "Special Problems of the Nursing Home Patient."

Craig Larson, MD, Milwaukee, chairman of the State Medical Society's Division on Aging, moderated the program. Topics covered included care in the areas of vision, dentistry, skin care, hearing, and gynecology.

Legal Responsibility

With the Wisconsin Hospital Association (WHA), the State Medical Society cosponsored a program October 22 in Oshkosh on "What is Our Legal Responsibility to Our Patients" as part of the WHA annual meeting.

Eric Spring, a Pittsburgh attorney specializing in medical law, told the assembled hospital personnel, "hospitals, physicians, nurses—indeed, all of the persons who make up the human component of the delivery system—are held to higher standards than ever before. They are subject to stricter surveillance than ever before."

Speaking of professional peer review, he termed it "not a punitive system; it is an educational and scientific system." He suggested that

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Council Asks Action on Menominee Health

Immediately before the House of Delegates Special Session convened, the State Medical Society's Council met and adopted a resolution suggesting Governor Lucey establish a special Menominee Health Care Commission to aid in solving health care problems among the Menominee Indians.

The resolution said the Society should appeal to the United States Public Health Service to locate a full-time National Health Service Corps physician in Menominee County by November 15. It said that if this cannot be done, the State Medical Society would seek to enlist volunteer physicians to staff a temporary clinic in the county on a part-time but regular basis until more permanent arrangements can be made.

WPS-25 Noted During Work Week of Health

The 25th anniversary of Wisconsin Physicians Service (WPS) was commemorated during the Wisconsin Work Week of Health as part of a special invitational program on "Progress in Voluntary Health Insurance."

National insurance executives, as well as representatives of Wisconsin business, labor, and government attended the day-long program October 21 at State Medical Society headquarters in Madison.

George R. Dunlop, MD, vice-chairman of the board of the National Association of Blue Shield Plans, was the leadoff speaker for the day and also presented a plaque in recognition of WPS-25 at the noon luncheon.

WPS Cited

He cited WPS as "showing the concern of the profession for delivery of medical care to the people at a reasonable cost."

The day's program was opened by Wisconsin Governor Patrick J. Lucey who noted that well before the establishment of Medicare, Wisconsin Physicians Service "recognized the need to improve the offerings available to senior citizens; since the enactment of Medicare, the Plan has continued to fill in the coverage gaps of Medicare and to extend further the benefits available to senior citizens."

Government involvement in health insurance was a focus for many of the speakers that followed.

National Health Insurance

Dr. Dunlop noted that "during the next few months the House Ways and Means Committee will have to make a philosophical decision about the direction the government will take in health care. Congress and the administration probably will support a proposal which will build on the present system."

In his speech Harold G. Pierce, senior vice-president of the Blue Cross Association, concurred, saying, "it is unlikely that any of the proposed forms of national health insurance will survive intact in the Congress."

He said the position of the Blue Cross Association is that all people should have access to health care, but that anything offered should be related to availability and should include a choice of health care programs for the consumer.

W. W. Keffer, chairman of the national Health Insurance Council, said that if the health insurance industry is to play a part in a restructured system of health care and national health insurance, "the public must have assurance of the fairness and reasonableness of our benefits and premiums. At present, we are subject to state regulation and to the very strict disciplines of the competitive marketplace; but the adequacy of these controls is being challenged, and a greater degree of federal involvement in the regulation of our business is under discussion in Washington."

Consumer Problems

Wisconsin State Insurance Commissioner Stanley C. DuRose contended that "the consumer is at a loss to know what he is buying and spending his dollars for. This is an inherent weakness of the insurance business."

He suggested that "there needs to be a basic minimum of coverage required. Then, given a basic minimum, there could be other types that would build on this."

Consumer advocate Mrs. Helen Nelson noted that as Americans move from place to place, from

Governor Lucey addresses WPS-25 group.

MDs E. J. Nordby, G. R. Dunlop, and G. A. Behnke with WPS commemorative plaque.

Work Week

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legal hospital responsibility for physicians' acts means "they should require a strong and operating medical staff organization which monitors the clinical, ethical, and professional activities of its individual members and is accountable for the competency, effectiveness, and quality of care rendered in the institution."

Alcoholism Conference

The State Medical Society cosponsored a second program on October 22 in Wausau with the Wisconsin Association on Alcoholism and Other Drug Abuse.

The luncheon speaker for "Alcoholism: The Worker, His Employer, and Third Party Purchasers" was Robert R. J. Hilker, MD, medical director of Illinois Bell Telephone Company.

Dr. Hilker outlined Illinois Bell's pioneer rehabilitation program for alcoholic employes. Started in 1951, the program is now called the Health Evaluation Program and it attempts to help employes solve any medical problem that prevents them from doing a good job.

Studies have shown that the majority of people treated in the program are emotionally ill, with the next highest number having alcohol problems.

The Wausau program included panels on alcoholism in industry and health insurance, and five workshops on different aspects of the problem.

Wisconsin Legislative Roundup

The following is a listing of the key bills and their status as of November 10, 1971. Most of these were among the bills published in the August GREEN SHEET and are reprinted here because of a change in status. (A denotes Assembly bill, S denotes Senate bill.) Further information on other bills and an updating of status will appear periodically in the GREEN SHEET, in legislative bulletins, and in special communication to officers of county societies.

Bill	*Subject*	*Current Status*
14, A.	ABORTION—introduced by Representative Barbee. Would remove abortions from the Statutes dealing with crimes. SMS has taken no position on any specific abortion legislation, because the question is currently being considered by the courts. Other bills on abortion include 600, A., 722, A. and 723, A.	Tabled
206, A.	GENERIC PRESCRIBING—introduced by over 40 Representatives. Would require physicians to prescribe by generic name and require labeling by generic name. SMS position is that before any legislative action is taken, there should be created a study committee to conduct an analysis of generic name prescribing to determine whether and to what extent therapeutic equivalency exists; cost savings to patients that might reasonably be anticipated; and cost of implementing such a program.	Referred to Joint Committee on Finance
482, A.	FAMILY PLANNING. Would provide for removal of contraceptives from statutory list of indecent articles. SMS SUPPORTS other family planning legislation (see Senate Bills 2 and 130), but has not taken a formal position on 482, A.	Tabled
521, A.	MEDICAL INTERNSHIPS. Would provide that no hospital could require an examination other than an examination required by the Medical Examining Board or one given by the hospital for selection purposes as a condition to being admitted to an internship. SMS OPPOSES this proposal because it would lessen present standards.	Tabled

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WPS-25

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job to job, they often are without health care protection. The vice-president of Consumers Federation of America and associate director of the University of Wisconsin Extension Center for Consumer Affairs, she said financing of health care should not be tied to location or job but should be available on a continuing basis for everyone.

Gerald R. Riso, deputy administrator of management and agency operations, Department of Health, Education and Welfare, said the problems involved in health care are complex and "any solution, public or private, that attempts to deal with only some of these, will tend to aggravate the problem."

He said the "health care crisis" includes such components as: maldistribution of health providers in the population, financial barriers to access to care within specific population groups, inadequacy of health protection benefits, and the financial crisis of medical and dental schools.

The mechanics of assuring good quality health care at a reasonable cost were discussed by a panel of three midwestern physicians.

Speaking on peer review, Lowell H. Steen, MD, a member of the AMA Committee on Community Health Care, said, "if any semblance of a private medical practice is to remain in the years to come, a big part of medicine's efforts should be directed to assuring that private financing and private delivery systems are effective, efficient, and are of high quality. Peer review can help us assure that these sacred traditions are maintained intact."

He said, "we cannot long survive in this complicated environment by saying that we do provide the best quality medical care available. We cannot long survive by saying that quantity delivered is neither too much nor too little. Nor can we survive by saying the cost is reasonable. We must document these facts. We must not only solve, but prove that we have solved the problems related to our profession."

On the same topic, Richard E. YaDeau, MD, president-elect of the Minnesota Foundation for Health Care, described audit as a mechanism to assure quality. Paul B. Mason, MD, chairman of the State Medical Society's Committee on Utilization Review Programs described how peer review functions in Wisconsin.

TOP: Speakers Mrs. Nelson; Reverend James T. Carrico, pastor of the First United Methodist Church, Wausau; and David N. Goldstein, MD, Kenosha, moderator.

BOTTOM: Speakers Steen and YaDeau.

707, A.	PHYSICIAN'S ASSISTANT. Provides that the Medical Examining Board shall establish standards for certifying individuals who hold themselves out as physician's assistants. SMS INTRODUCED AND SUPPORTED THIS LEGISLATION.	Passed Assembly; sent to Senate Health and Social Services Committee
1104, A.	CERTIFICATE OF NEED would require the Department of Health and Social Services to issue a certificate based on need when a new health care institution was being constructed or an existing one altered. The Society recognized that a bill to require health planning agency approval should be enacted for *licensed* institutions, but does not favor the inclusion of unlicensed private facilities and professional services in such a proposal.	Hearing held by Assembly Health and Social Services Committee which has recommended passage
1105, A.	VD TREATMENT FOR MINORS was introduced by the Assembly Committee on Health and Social Services at the request of the State Medical Society and would allow a physician to treat minors for venereal disease without obtaining the consent of the minor's parent or guardian. SMS SUPPORTS.	Tabled
1227, A.	STAFFING OF HOSPITALS—introduced by Representative Tobiasz (D–Milwaukee). Would require that at least one qualified physician be on duty at all times at every hospital. SMS does not oppose the principle of this proposal, but does OPPOSE the bill on the basis that it would be impossible to implement with the current manpower shortage and could force some hospitals to close.	Hearing held by Assembly Health and Social Services Committee
1391, A.	EMPLOYMENT OF PHYSICIANS BY HOSPITALS—introduced by Representative Czerwinski (D–Milwaukee) at request of the Governor. Would allow hospitals to employ physicians. The House of Delegates of the State Medical Society has recognized that employment of physicians may be necessary in some situations, but feels that any legislation must include the following if the interests of the patient and the physician are to be safeguarded: 1. Require contracts of employment be approved and supervised by the hospital's medical staff and filed with the Medical Examining Board. 2. Prohibit the limitation of medical staff membership in a hospital only to physicians employed by the hospital. 3. Continue the prohibition against hospital interference with the manner in which medicine is practiced. 4. Provide that the physician retain full professional liability for the patient's welfare. 5. Grant physicians full rights as employes, including the right of collective bargaining with the employer.	Referred to Assembly Health and Social Services Committee
2, S.	FAMILY PLANNING—introduced by Senator Soik (R–Whitefish Bay). Would remove contraceptives from the list of indecent articles and enable sale by physician or pharmacist. Sale would be restricted to those over age 18 except under certain circumstances. SMS SUPPORTS with amendment to remove age limitations.	Indefinitely postponed
55, S.	JOINT SURVEY COMMITTEE ON LICENSING—introduced by the Legislative Council. SMS SUPPORTS the concept but not in form proposed by this legislation.	Referred to Joint Committee on Finance
202, S.	CHIROPRACTIC AND PRIVATE HEALTH INSURERS—introduced by Senate Committee on Health and Social Services. Would make it mandatory for private health insurance plans to provide coverage for chiropractic services. SMS OPPOSES.	Senate Health and Social Services Committee has recommended passage
203, S.	CHIROPRACTIC SERVICES UNDER MEDICAID (TITLE 19)—introduced by Senate Committee on Health and Social Services. Would require payment for chiropractic under Medicaid. SMS OPPOSES.	Public hearing held by Senate Health and Social Services Committee
238, S.	PODIATRY—introduced by 17 Senators and 15 Representatives. This bill would give podiatrists the unrestricted right to use narcotic drugs and allow them to amputate toes. SMS OPPOSED unless educational qualifications were demonstrated by podiatrists.	Passed—Chapter No. 71
419, S.	DISTINGUISHED VISITING MEDICAL PROFESSORS—introduced by Senators Murphy, Chilsen, Devitt and Lorge. Would permit the Medical Examining Board to issue a temporary license to practice medicine, for a period of up to six years, for a graduate of a foreign medical school who is a visiting professor at a Wisconsin medical school. SMS SUPPORTS.	Passed Senate and Assembly
Senate Joint Res. 33	MEDICAL EXAMINER SYSTEM. Permits a county or group of counties to create a medical examiner system in lieu of the office of coroner. SMS SUPPORTED.	Passed—Chapter No. 21
593, S.	KIDNEY DISEASE AID. Proposes to establish a program of state aid to supplement the cost of kidney disease treatment. A board would be created to supervise patients and treatment centers. SMS SUPPORTS THE PRINCIPLE, BUT FEELS THIS WOULD BE BETTER HANDLED AS CATASTROPHIC CARE UNDER INSURANCE RATHER THAN BY STATE FINANCING.	Senate Health and Social Services Committee recommended passage; referred to Joint Committee on Finance

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The Annual Meeting

PRESIDENT'S PAGE

THE FORMAT FOR THE ANNUAL MEETING has been and is of serious concern to your president.

The attendance at the Annual Meeting has fluctuated but, as in other states, the trend is downward. However, we may be able to take some comfort in the fact that the percentage of the Society's total membership attending the Wisconsin Annual Meeting remains higher than most of our neighbor states. In 1971, for example, 29% of the Wisconsin membership attended the annual session. In Iowa, the percentage was 19; Minnesota—29; Illinois—12; Michigan—13; and Indiana—24. At the same time, pharmaceutical manufacturers are limiting the number and places of their exhibits with the result that state medical societies are assuming a greater proportion of their annual meeting costs.

It also has been increasingly difficult to obtain the most desirable level of attendance at all the House of Delegates' meetings. It seems to me that with as many legislative and other important matters coming before the House, attendance at the meetings is a must if we are to be representative of our members.

The Commission on Scientific Medicine has worked diligently to present a good program that has had an appeal to as great a number of physicians as possible. It is difficult when a number of sections have withdrawn from participation in the annual session and others are considering this move.

An ad hoc committee composed of Doctors T. J. Foley, Milwaukee, Chairman; R. T. Lewis, Marshfield; G. J. Derus, Madison; N. O. Becker, Fond du Lac; G. A. Gerglund, Milwaukee; and S. B. Gundersen, Jr., La Crosse, has been appointed to make recommendations. I'm sure any of these men would welcome suggestions from the general membership.

I think a number of possibilities should be considered. Should we continue scientific meetings and House of Delegates meetings as we have in the past? Should the scientific meetings be shortened to one or two days and held at separate times from the House of Delegates? Should the entire format be changed and should the Annual Meeting be purely a business meeting with general sessions or purely socio-economic and legislative matters that concern all facets of medicine? This would then allow the different sections and the WAGP to set up their own scientific sessions whenever they wish. There are no doubt many other alternative suggestions.

I think that all members must seriously consider the problem and express their ideas to the ad hoc committee. Only in this way can we present a meeting that will be attractive to most members and still allow the Society to conduct its very necessary business.

G. A. Behnke M.D.

G. A. BEHNKE, MD

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EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

Justice Is a Sometimes Thing

"High and low, and young and old"

All men are differently endowed and differently treated in this world. Each one of us, if questioned, would say we believe in "justice" and, if pressed further, would say that for the most part "justice" does prevail. By this we might mean that a person gets what he deserves, whether that be fame, fortune, and happiness in exchange for hard work, honesty, and trust, or whether the just deserts be pain, shame, and other punishments for failure to meet the world's demands.

We all went to medical school, perhaps one of the best examples of hard work and perserverance. Some worked harder than others, but all submitted themselves for varying periods to the discipline of those older and more experienced physicians who clustered about the medical schools. Now we find to our dismay that our colleagues may judge us as to adequacy, that our patients may love us as individuals but insist on right of choice of some other method of treatment, and that our public in general insists that we no longer know all the answers to medical questions.

On the first point, the rapidly increasing complex of peer judgments, utilization reviews, surgical pathology committees, and the like have shorn the doctor of today of any bit of feeling he may have had about his autonomy as a practitioner of medicine. The scientific training proves not so golden after all, at least it ceases to be golden of itself, and becomes so only when it matches the thinking of elected (popular or charismatic?) members of our group, and even this must take its chances on the computer at Ann Arbor, itself a composite of all we send to it.

Our second narcissistic blow comes when patients seem to desert us. In this day of scarcity of medical services there is no financial worry as a rule, for another patient soon fills the empty spot. I doubt if any one of us has not felt a challenge to our scientific position when a patient just fails to return or calls to cancel. That they should reject our carefully won knowledge seems hardly comprehensible to us, for did we not learn it by long years of arduous work? That they should abandon us for another doctor, or for a chiropractor, osteopath, or some institutional group in still another state, or perhaps some still more foreign method of getting help for their hurts (hypnosis, Christian science, or

what not)—any of these do violence to the notions of scientific justice to which we are accustomed. In the light of our medical school teaching, the new chiropractic law makes no sense. In the light of the more direct thinking of the modern man, it presents no contradiction and no injustice. How does he think? He thinks that the world is so excellent, at least at the technical level, that it must have been produced by nature. He cannot think of the personal effort of endowed individuals nor of their discipline of mind which the creation of this "magic world" of medicine (and other creature comforts) has presupposed. From his point of view there is no justice or injustice in taking what seems good and available. To our scientifically oriented minds this all seems gross injustice, or at least that justice is but a sometimes thing. This is why our organized and logical attacks on the chiropractic, or on the fluoride-phobia people, fall so short. It is not really injustice if looked at this way, and just maybe might be countered more effectively from this base, rather than from continued, apparently ineffective though logical bases. How many editorials have you read about how good fluoride was and how bad chiropractic? For all our scientific training we seem to insist that others use our logical schemes, then become petulant, or resigned, and certainly defeated, when they do not hear.

The last point, the crowding out of physician know-how by ancillary groups, by consumer groups, and by political groups, has been commented about in previous editorials. It is mentioned here only to emphasize that we might walk again into a logical trap and not know what has hit us. To cry "injustice" at such times only makes us sound paranoid. It is like having the right of way yet being crippled by an auto accident. When enough people say "science" is fine but I want "help," the duly elected representatives will respond to this implied dichotomy. We will feel hurt and subjected to injustices. Justice requires not only awareness of what rests in each pan of the scale but also of what controls the fulcrum—the effective point for judgment.

—RH

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Health Information—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Drug Abuse, Health Careers, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

Can the Lay Public Save Hearts?

Much has been written recently concerning the epidemic of arteriosclerotic heart disease in this country, and in fact the world, and it is well known that most of the deaths that occur due to this disease are outside the hospital. The thrust of future medical care for this disease must therefore rely upon getting help to the patient early.

A few statistics to remind the reader of the extent of this problem. There are 1.8 million deaths in the United States due to all causes, 600,000 of them are due to arteriosclerotic heart disease. Of these, two-thirds die outside the hospital. Of those who die, about one-third die within 15 minutes (and therefore are presumably beyond help). If one considers only the two-thirds of those patients who die outside the hospital but go beyond 15 to 30 minutes, the average lag time of this proportion of patients before actually dying is around three hours. This principal delay is due to patient delay in calling for help and not due to the delay in transporting patients to the hospital. However, there is a further delay within hospital emergency rooms before the patient is taken to a coronary care unit. We shall not discuss this latter problem but confine ourselves primarily to out of hospital patient deaths.

Of patients having their first myocardial infarction, one-third will die. Of those having a second myocardial infarction, over fifty percent will die, and a second myocardial infarction risk is greatest in the first five months after the first myocardial infarction.

From all that can be surmised from the studies done on out of hospital patient deaths and the work done in coronary care units, most of the patients having their first and second myocardial infarctions die of a rhythm disturbance rather than pump failure. The obvious tragedy of this is that the patient may well be dying with a relatively good myocardium with a "short circuit" tachyarrhythmia.

Therefore, it is necessary to stabilize the rhythm of patients with myocardial infarctions as early as possible and to get the patient to intensive coronary care units as soon as possible. The scope of this is too vast for the present medical personnel to accept as solely responsible, and it is my opinion that we need to engage lay personnel in getting to the patients in the home quickly.

It is possible to obtain a significant blood level of Xylocaine (Lidocaine) with intramuscular injection in the deltoid muscles with a dose of perhaps 200 to 250 mg. This blood level may be seen to occur within six minutes of the time of deep muscular injection.

It is well known that Atropine may be given intramuscularly with good blood levels in a relatively short time. These two drugs are the main stay of stabilization of rhythm disturbances in patients with acute myocardial infarction.

It is my proposal that we create a series of "block wardens" in a metropolitan area that consists of lay personnel who have been trained in the use of intramuscular injections and who have been trained in giving either one or the other drug depending upon the cardiac rate (rate over 50 dictating the use of Lidocaine and a rate of under 50 dictating the use of Atropine). A call into a central phone number could initiate discovery of the lay person in the area available at the time and bring help to the suspected victim early, without cost. The "heart watcher" could then not only give Lidocaine or Atropine to stabilize rhythm but could also help to call for help for the patient who would be transferred to an emergency room or a coronary care unit for further care. This program which allows for the patient to call in a third person readily and to receive such medication would seem to me to be potentially life saving for many of the victims of acute myocardial infarction. If only ten percent of the patients who die at home could be salvaged with such a program, it would effectively allow for ten times as many patients to be saved as are being saved in the coronary care units now existing in the United States.

A bill now being introduced into the state legislature by Mr. Barbee, a state representative, will allow freedom from suit or claim by any person getting Lidocaine or Atropine who has been trained properly in the use of intramuscular injections. It is hoped that this will circumvent any legal blocks into the institution of such a program.

It is, however, necessary for the medical profession to accept such a program and to encourage their patients in participating in this program. It is particularly so, of course, with any high risk individuals such as those who are known to have hypertension, those who have had a diagnosis of arteriosclerotic heart disease already established, and those who are diabetics who are hypercholesterolemics.

It has been recommended that if we cannot start on an entire community wide participation that perhaps we should start smaller with only those people who are high risk individuals and those who can train family members to inject this drug readily by themselves, such as the physicians. While it would be more appropriate to look forward to the state wide lay participation in this field, I think it might well be worthwhile starting smaller if the former is not possible immediately.

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

It will be said that the delay in getting help of patients who have myocardial infarctions is primarily due to the delay in the patient himself in calling for help, and this is in fact true. It should also be noted that the presence of a third person within the area at the time that the patient had myocardial infarction significantly decreased the lag time in the patient receiving help and calling for help. This program makes available to a patient a third person to whom he may turn for help when questioning his own situation, or in fact, at a time when he is trying to deny his illness as often seems the case. This availability of a third person at no embarrassment or cost to the patient may in fact allow the help to be obtained much earlier.

It is hoped that until arteriosclerotic heart disease can be more effectively prevented, that we must more effectively treat the large treatable area of arteriosclerotic heart disease—that of rhythm disturbance; and the above plan is an attempt to handle this situation.

W. D. SHAPIRO, MD
Milwaukee

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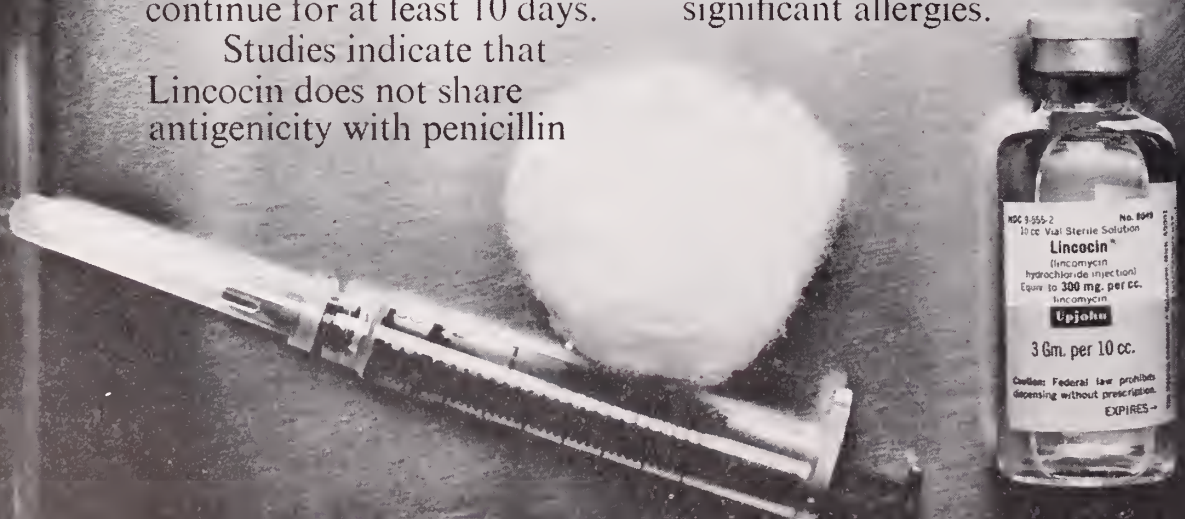


Howard Culbertson
Harvey Hospital Surgeon

MEDICAL HISTORY FEATURE

By William S. Middleton, MD
Madison, Wisconsin

THE IMPACT of the Civil War on the social and economic life of Madison was overwhelming. Sharing this effect with all other communities of the country by the enlistment of large numbers of the adult male population and the readjustment for provisioning and arming a growing military organization, the establishment of Camp Randall within its city limits added local problems. These assume an increasing significance when certain relative figures are brought to mind. In the years 1861–65 the population of Madison did not exceed 6,611. The University of Wisconsin, with all preparatory, normal, and special students included, had an enrollment of approximately 300. The influx of 4,500 young men for training at Camp Randall at a given time created natural exigencies for their accommodation and acceptance in this small community. In all some 70,000 soldiers passed through Camp Randall for training in the service of their country during the War.

Under the circumstances differences arose between the trainees and the civilian population. While the military group entered actively into the social life, certain disturbances attributed to alcoholic overindulgence on their part led to the passage of a bill by the State Senate (1862) prohibiting the sale of liquor to soldiers within three miles of any camp in the State with the penalty of a fine of $25. The mutiny of the 17th Regiment on the night of March 19–20, 1862, resulted in the death of two soldiers and the burning of a 200-foot barracks. In extenuation of the unrest of the troops, there had been a failure to afford promised relief to dependents and personal pay to the soldiers themselves. In fact 3,000 claims were at the moment unfilled in the office of the Secretary of State. Naturally the insubordination and upheaval of Camp Randall deeply concerned the people of Madison and an armed patrol of the city to prevent disorder and violence was proposed. By poetic license the 17th (Irish) Regiment was brought under control by a detail of 160 Mulligan guards from another regiment!

However, the most effective figure in this crisis was the lately inaugurated Governor Louis Powell Harvey (January 6, 1862). His statesmanly address to the joint Session of the Assembly and Senate (January 10, 1862) set the tone for his subsequent activities. His forthright advocacy of the cause of the neglected Wisconsin troops won their complete confidence. Indeed, he went in person to St. Louis to insure the fulfillment of his pledge (March 28, 1862).

Military events in the field were shortly to dominate the situation. Wisconsin troops were engaged and incurred heavy casualties in the Battle of Shiloh (Pittsburg Landing), April 7, 1862. With word of the suffering of these troops, Governor Harvey reacted characteristically by directing the collection of supplies and equipment for their needs. In person he led a relief party to the Southern scene (April 10, 1862). Here he visited the hospitals and camps to direct the distribution of the material brought from Wisconsin. His personal correspondence indicated great personal gratification in the success of their mission in ameliorating the requirements of sick and wounded. With their objective accomplished, the party turned north. However, in attempting to transfer from one river boat to another on a dark rainy night (Apr. 19, 1862), Harvey plunged into the Tennessee River and was drowned.

Clearly the man of the hour, the shock of Governor Harvey's death was widely felt. With commendable fortitude, his wife, Cordelia Perrine Harvey, took up the torch from her fallen husband's hand. As Sanitary Agent for Wisconsin under a commission from Governor Edward Solomon, she immediately went South to gain a personal evaluation of the medical care of Wisconsin troops. In appreciation of her efforts in their behalf, the soldiers called her the Wisconsin angel. Her attention was early directed to the effect of the climate on the convalescence of the sick and wounded. Then came a personal experience, when apparently only a movement to the North restored her normal vigor. From that time Mrs. Harvey was an earnest advocate of convalescent hospitals in the North for the debilitated sick and disabled Wisconsin troops, languishing, as she observed, in the South. Obviously her impassioned appeal to Governor Solomon could not reverse the Federal opposition to convalescent hospitals in the North.

Fig. 1—Surgeon Howard Culbertson.

Although Governor Solomon did place the situation clearly before the Senate of Wisconsin with the recommendation that they memorialize President Lincoln in this matter, the gesture was fruitless. However, through the intermediation of Senator Doolittle, an audience with the President was arranged for Mrs.

Presented before the William Snow Miller Medical History Seminar, Nov. 18, 1970, University of Wisconsin, Madison.

Harvey. Dramatic accounts of the interchange between these strong characters have been preserved. Obviously Mr. Lincoln at first resented the intrusion of this ardent protagonist. He presented the problems of disaffection and desertion that attended withdrawal of troops from the combat areas. Mrs. Harvey maintained that her appeal was not for deserters and criminals but for the disabled soldiers in the hospitals of the South, whose health and lives were in jeopardy from illness and wounds incurred in defense of their country. Ultimately relenting, President Lincoln wrote to Secretary Stanton, "Admit Mrs. Harvey at once. Listen to what she says. She is a lady of intelligence, and talks sense. A. Lincoln."

Won to Mrs. Harvey's position, the President discussed the name of the proposed hospital. Appropriately it was agreed to term it the Harvey United States General Hospital in memory of her husband. Despite some desultory objections, the Farwell mansion at Spaight and Brearly streets, Madison, was selected for this purpose over the Water Cure Sanitarium. This octagonal limestone house had been built at a cost of $45,000 by former Governor Leonard J. Farwell (1847). This mansion constituted a substantial nucleus for remodeling and extensive expansion. By December 30, 1863, there were 214 convalescent soldiers on its rolls. On New Year's Day, 1864, the citizens of Madison served them a sumptuous dinner. With the completion of the new wing of the Hospital (February 23, 1864), Surgeon Culbertson officially greeted a representative audience of townspeople. In his speech he gave due credit to Mrs. Harvey for her vision and pertinacity in achieving her objective. The *Wisconsin State Journal* (February 25, 1864) concluded, "The hall is as snug and neat as a choice design, wood and plaster as white as snow, and has full and convenient ventilating arrangements. The ward hall below is very commodious, and seems to possess every required advantage." In the Medical and Surgical History of the War of the Rebellion, Harvey Hospital was rated as 592-bed capacity with 100 percent occupancy. In explanation of its low mortality (1.94%), it was stated, "The inmates of this establishment were generally chronic cases or convalescents who had passed the dangerous period of their attack at some hospital near the front." At a later period, the hospital at Camp Randall came under the administrative control of Harvey Hospital.

As the officer in charge, Surgeon Howard Culbertson, United States Volunteers (Fig 1) won the respect of the community and the confidence of the sick and wounded soldiers. It is a singular commentary on his superior attributes that his professional attainments were as conspicuous as his administrative ability. Born to Reverend James and Elenor (Calhoun) Culbertson in Zanesville, Ohio, February 4, 1828, Howard was frail in childhood. The death of his father when he was quite young, led the lad at age 17 to become a machinist in Cincinnati. Although the task proved too arduous for him, he never lost his interest in mechanical devices. Returning to Zanesville, he elected medicine as a career. He read medicine in the office of Dr. Lyman Little. Culbertson attended the first course of lectures at Ohio Medical College, Cincinnati. The second course was taken at Jefferson Medical College, where he was granted his medical degree in 1850. Thereupon he practiced in his native city and earned some local reputation by his success in the treatment of diseases of the eye.

However, unusual distinction came to Culbertson by winning the gold medal of the Ohio State Medical Society with his Prize Essay on "The Use of Anesthetics in Obstetrics" in 1862. This Essay embodied the classical approach by Biblical quotations and detailed discussions of the anatomy and physiology of the female generative tract in the normal, pregnant, and parturient woman. The relationship of the fetus to the mother was emphasized. Interestingly Culbertson anaesthetized two pigs; one with ether, the other with chloroform. He decided that both acted first upon the blood, then the blood vessels, and lastly on the nervous system. Chloroform produced darker blood than ether in the experimental animals. He hypothesized that the interruption of aeration resulted "not only from the retained carbonaceous matter, but from the want of oxygen." Observations of the web of a frog's foot under the microscope disclosed an early capillary excitation followed by relaxation and dilatation on the topical application of a drop of chloroform. If the anaesthetic agent were given by inhalation, primary contraction of the web capillaries was succeeded by dilatation and "at stasis they are clogged with globules." By inference Culbertson extended these changes to the central nervous system. Quite interesting was his report of the resuscitation of a pig, killed by etherization, through galvanic stimulation of the diaphragm. Singularly he reviewed the literature (3,247 cases) to establish the safety and propriety of the use of the anaesthetic agents in labor—a stupendous task; but somewhat detracting was the limitation of the author's experience to 16 cases. He carefully outlined the indications and contraindications. Among the 25 listed conclusions were his maintenance of the innocuousness of anaesthetics to the infant, the relaxation of the perineum, cervix and os uteri, and positive parturient action to the body and fundus uteri in the mother. He remarked the advantage of these agents in "unnatural cases of labor" to render them "more readily amenable to the medical art." In his judgment, ether was more stimulating and chloroform more sedating. He preferred the latter for deep anaesthesia. In general he decried too heavy dosage of the agents and advised partial insensitivity rather than unconsciousness except under unusual circumstances.

The hostilities of the Civil War made military service imperative for many physicians. From August 11 to September 13, 1862, Culbertson was Acting Assistant Surgeon, Ohio Volunteers, at a camp near Zanesville. November 7, 1863, he was appointed Surgeon, United States Volunteers. His first assignment was in charge of the hospitals at Rolla, Missouri, where his conspicuous success in restoring order to the post attracted the attention of his superior officers. With the activation of the Harvey Hospital, he was transferred to Madison (1863). Notices of Surgeon Culbertson's activities as the officer in charge of this Hospital in the contemporary press convey the impression of a high measure of administrative competence. He met the common issues with dignity and dispatch. Giving due credit to his staff, he ran a "tidy ship."

Rather to his professional activities, attention is directed in

the present relation. Culbertson contributed some 25 items to the Medical and Surgical History of the War of the Rebellion. A number of pathological specimens were submitted by him to the Museum. They ranged from mesenteric thrombosis and pseudomembranous colitis to numerous specimens of bony lesions. His accounts of surgical procedures and their results were meticulous in detail and objective in evaluation. Pvt. J. Campbell, 6th Wisconsin Volunteers, sustained a gunshot wound of the forearm with fractures of the upper and middle thirds of the left ulna. He described the caries of the adjacent fragments and the overlapping at the imperfect union with a gaping opening over the seat of fracture. Culbertson removed three inches of the ulna (August 9, 1864). "On the second day gangrene appeared, which was arrested with nitric acid locally and tincture of muriate of iron with quinine internally. 23d wound healing kindly by granulations." The specimen of the ulna was sent to the Museum. However, loss of tissue and contracture of the extensor muscles left a shrunken forearm, so that Examiner W. A. Gobb reported (April 15, 1873), "The power of extension is very limited and must always remain so."

The case record (below) from Harvey Hospital has been lifted directly from the Medical and Surgical History of the War of the Rebellion.

Particular attention is directed to the attending and consulting surgeons cited in this instance. Surgeon General E. B. Wolcott was the grandfather of the late John Lawrence Yates of Milwaukee. John Favill was the grandfather of H. Kent Tenney of Madison.

Aside from the immediate surgical procedures, the management of war wounds at that

CASE 484.—Private F. Luck, Co. C, 21st Wisconsin, aged 21 years, was wounded in the right knee, at Chaplin Hills, October 8, 1862. He was admitted to hospital No. 7, Perryville, and discharged from service February 15, 1863, Surgeon J. G. Hatchett, U. S. V., certifying to "complete destruction of the use of the knee," as resulting from the injury. On the 2d day of the following December the man entered Harvey Hospital, at Madison, whence Surgeon H. Culbertson, U. S. V., contributed the pathological specimen (No. 2074, *Surgical Section,* A. M. M.), with the following report: "This soldier received a penetrating wound of the knee joint, and was unfortunately discharged at the breaking up of the Perryville Hospital, when the knee was still running and not in progress of cure. The injury was caused by a minié ball, which entered posteriorly and to the inside of the tuberosity of the external condyle of the femur, passed obliquely forward and slightly inward, fracturing the external condyle and also the upper and outer margin of the patella, and came out opposite that point of the bone. True and false anchylosis resulted, the former between the inner condyle and head of tibia, and necrosis of the inner condyle ensued. At the time of the patient's admission the state of the parts was as follows: The joint was enlarged and the wound open over the external condyle, and some three inches higher up the thigh another opening existed, both of which discharged unhealthy pus. There was also periostitis extending up as high as the lower fourth of the femur, and the soft parts about the joint were swollen and indurated up to the middle third of the thigh. Circulation below the knee was extremely feeble, and the leg, bent upon the thigh at right angle, was extremely emaciated. The patient's constitution showed marked evidence of scrofulous diathesis. At first I determined to treat the case by resection of the joint, but on reflecting, and with the advice of Dr. E. B. Wolcott, Surgeon General of Wisconsin, I decided upon amputation as affording the best and safest means for the removal of the disease. Just before the operation, which was done on January 3, 1864, the patient fell upon the floor and broke the union between the tibia and inner condyle of femur; yet from the inflammatory exudations thrown out about the joint it was found impossible to straighten the limb, though efforts were made to effect this object while he was under the influence of chloroform. I performed the amputation at the middle third of the thigh, by the circular method, in the presence of Dr. Wolcott, Acting Assistant Surgeons J. J. Brown and J. Favill, and Medical Cadet W. B. Buckley. Nothing unfavorable occurred, and the wound healed by first intention, though the ligature applied to the femoral artery has not yet (February 7th) come away. The stump now certainly demonstrates the superiority of the circular over the flap operation of this member, being one of the most perfect in form I have yet seen. This case illustrates the efforts of nature to diminish the capacity of the joint by anchylosis and the exudation into it of plastic organizable material; also the fact that penetrating gunshot wounds of the knee joint will require amputation, even though nature be given fifteen months in which to effect a cure. On examination of the morbid specimen, it will be seen that the ball passed through the cancellated structure of the external condyle, entering the cavity of the joint only at two opposite points, thus inflicting upon the synovial membrane but a slight wound so far as extent is concerned. Unquestionably great inflammation must have followed the wound, as is proved by the effects observable. But nature could not have been as successful had the external condyle been broken into fragments. It was in fact a penetrating wound of a portion of the joint which inflicted great injury to it, and yet it was singularly and uncommonly local, the wound of the bone appearing as though it might have been made with a circular punch. The fact that the bones entering into the formation of the joint were injured in so limited a manner would seem to be the reason why amputation was not required long since." Dr. Culbertson appends the following remark to this history: "This case is cited not because of the amputation performed, but to illustrate the great efforts of nature in the cure of penetrating gunshot wounds of knee joints, and also her failure in the attempt." Three months after the operation the patient was well enough to proceed to Chicago for the purpose of being fitted with an artificial limb, and on May 28, 1864, he left the hospital for his home. The pensioner was paid June 4, 1879.

time affords much food for thought. "Healthy" pus was commonly remarked. Apparently this description took the place of the laudable pus of an earlier generation. At times wounds were left open or, again, covered with lint and poultices. Occasionally lint dressings were saturated with liquor ferri persulphatis as a styptic. The salubrious effect of chloroform was cited so infrequently as to make obvious its short supply. In an isolated instance, one grain of morphine was given to a patient immediately postoperatively and repeated as required. (No comment!) Whiskey, quinine, and muriated tincture of iron were widely used in the postoperative period.

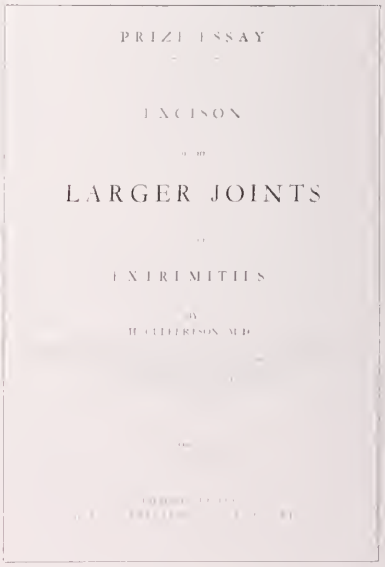
Significant in Culbertson's reports, as in the Medical and Surgical History in general, is the absence of any reference to disinfectant or antiseptic therapy, until one reflects that Joseph Lister's epochal discovery postdated the Civil War. Pasteur had broken the fallow field of microbiology. Attracted by these basic studies but denied the thermal control of bacterial growth, Lister explored the chemical approach. In 1865 after trials of zinc chloride and sulphate, he used carbolic acid successfully in the treatment of a compound fracture. In 1867 two papers by Lister appeared in the *Lancet*. The second of these, "On the Antiseptic Principle in the Practice of Surgery," revolutionized surgical thought and practice. However, Lister's principle did not receive immediate or universal acceptance at the hands of the medical profession. In the United States, for example, Samuel D. Gross (1805–84), one of the leading surgeons and teachers of the period, thus addressed his class at Jefferson Medical College, "I have told you what there is to know about antisepsis. I am required to do so by the Board of Trustees. You can take it for what it's worth. Personally I don't think it's worth a damn." Fortunately the relationship between these great leaders closed on a happier note. Meeting Lord Lister at an international meeting, Gross was so impressed by his natural grace and modesty that they became good friends and thereafter the principle of antisepsis prevailed in Gross' clinic.

With the cessation of hostilities, the customary confusion of demobilization and reorientation led to the early liquidation of the convalescent hospitals in the North. Beginning May 29, 1865, the patients in Harvey Hospital were transferred to the hospital at Camp Randall. Still convoys of convalescent soldiers were received at Harvey Hospital as late as July 2, 1865. However, on September 9, 1865, official orders to close all general hospitals in Wisconsin were received from Washington. On September 27, 1865, the sale of the equipment and supplies of Harvey Hospital was advertised in the local press. Its guardian angel, Mrs. Harvey, was nonetheless alert to the possibility of its continued utilization. Her proposal of its transformation to "The Soldiers' Orphans' House" found general approbation. On March 31, 1866, the State of Wisconsin purchased it from the Federal government for $10,000. Significantly the project was already a fait accompli, for on January 1, 1866, 84 war orphans were registered in the Home.

Returning to the subject of our study, Surgeon Culbertson left Madison October 1, 1865, and served as Acting Assistant Surgeon at Camp Butler, Illinois, from November 15, 1865, to December 25, 1865. He was mustered out of service as Brevet Lieutenant Colonel "for faithful and meritorious service." Apparently the military career appealed to him for on February 28, 1866, he was appointed Assistant Surgeon in the Regular Army. In this capacity the rank of Captain was granted July 8, 1866. A succession of assignments took Culbertson to stations in Louisville, Memphis, and Baton Rouge. He was on sick leave with "congestive fever" from May to August 1868. The following year he was forced to resign from service "with health permanently undermined."

Culbertson returned to Zanesville and resumed his practice with especial attention to otology and ophthalmology. He soon rose to leadership in his native state. Singularly his major contribution to the medical literature was his monumental "Prize Essay. Excision of the Larger Joints of the Extremities" (1876) (Fig 2). National notice of this review was assured by the competition under the auspices of the American Medical Association. Louis Sayre of New York thus extolled the man and his effort, "Gentlemen, I have the honor to present to you a man who has accomplished a task which no other man in the United States would have had the courage to undertake and patience to finish." "The Essay" encompasses 662 pages, of which 436 are in the tabular analyses. Incidentally Joseph Lister (1827–1912) had first gained professional notice in the surgical world by his report of excision of the wrist joint for caries (1865). Culbertson was most generous in his acknowledgment of sources and assistance in this prodigious compilation. In all, 3,908 excisions of the larger joints of the extremities were reviewed. He had personally circularized 3,000 physicians. From this approach 467 returns (of the total) were gleaned. The format is orderly, if exhausting. At times the reviewer is reminded of Justice Cardozo's trenchant characterization, "There is an accuracy that defeats itself by overemphasis of details." The historical evolution of the excision of each joint, with particular reference to priority, is meticulously pursued. In general the anatomy of the joint, supplemented by appropriate plates, is given. The surgical approach follows as a rule. In the appended tables for each case there appear a series of cogent details, viz. surgeon, age, nature of lesion, form of incision, operation, bone removed, shortening, usefulness, et al. In such a maze of data, analyses become involved. Particularly is this true where specific criteria are grouped by the nationality of the surgeons and the season. When numbers are inadequate, statistical significance fades.

Fig. 2—Title page of "Prize Essay."


PRIZE ESSAY

EXCISION

LARGER JOINTS

EXTREMITIES

However, certain deductions may be gathered from Culbertson's careful studies. Almost verbatim in speaking of the hip, he concluded as had Paulus Aegineta (625–690): "The danger, then, of these excisions increases as the pelvis is more involved in disease. One might say that the mortality center is at the head of the femur, the rate diminishing as the bone is removed outwards along the femur, but increasing as it advances inwards upon the pelvis." Repeated comparisons of the mortality from comparable operations in hospitals and in private homes are offered. With few exceptions the figures favor the private dwelling—a circumstance that may appropriately reflect the chances of infection in the two locations at that time. The advent of antiseptic technique is witnessed by the regular use of weak carbolic acid to moisten the lint dressings that were supplemented by frequent washing of the wound with the same solution. Culbertson admonished, "The most scrupulous cleanliness of the wound and the person of the patient should be maintained, and the room thoroughly disinfected. Local inflammation of the joint may be modified by ice in bladders, or by irrigation either with cold or hot water, aided by other general or local remedial measures." Obviously Listerian principles prevailed.

Unusual interest attaches to Case 418 in the tabular analysis of Excision of the Hip for Disease and Injuries. In a letter (1872) the case record of a lad of 10 was transmitted by N. Senn of Ashford, Wisconsin, (1844–1909) for morbus coxae of traumatic origin. Senn found an abscess about the hip. A portion of the head of the femur was sacrificed and the periosteum separated. Six inches of the femur were removed. Yet the outline stated that only 1¼ inches shortening of the leg resulted. Senn reported, "At 4 months can rest whole weight on limb; wound entirely healed; firm union at hip." Nicholas Senn left Elmore (Ashford) for Milwaukee in 1874. In 1893 he took permanent residence in Chicago where he won international fame.

Culbertson advocated early passive and active exercise after surgery of the joints. He decried too protracted dependence on slings, canes, and crutches. Mobilization was imperative and occasional recourse to electrical stimulation was advised in selected cases. Of particular interest were his objective analyses of the end results. Arbitrarily in assessing "Usefulness", he used these categories: (a) perfect, without artificial support, (b) useful, with or without support, and (c) worthless, in which case he not infrequently recommended amputation. In a word, he weighed the results on a strictly functional basis and there was no compromise in this classification.

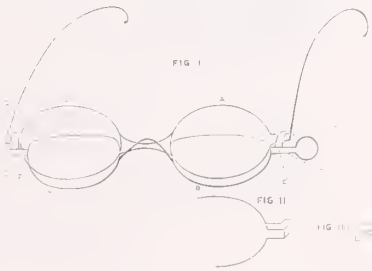
Appreciating the fact that the accumulated data covered several decades as well as a host of contributors with varying philosophies and facilities, a wide range of results might be anticipated. Singularly the extent of the injury and the degree of bone sacrificed did not correlate regularly with the functional gain or the mortality. Culbertson reported lower death rates in excision of the shoulder joint (21.5%) than did Gross with amputation (45.4%). Perhaps the most revealing figures relate to the deaths from causes other than trauma and surgery. Exhaustion was given as a common lethal factor. Pyemia was not unexpected in the period under consideration. A surprisingly high incidence of phthisis was encountered. Erysipelas, Bright's disease, and amyloid degeneration were occasional offenders.

Meanwhile Culbertson's practice in Zanesville, that had increasingly been limited to diseases of the eye and ear, prospered. In spite of his precarious state of health, he applied himself assiduously to his special interests. An unusual situation gave him his sole academic opportunity. In 1874, the chair of Materia Medica at Starling Medical College was vacated. Professor John W. Hamilton (Surgery) and Professor Starling Loving (Medicine) nominated different candidates for the vacancy. Since the By-laws of the Board of Trustees specifically required a unanimous vote for a given candidate from the faculty, there was an impasse. Neither principal would compromise or acquiesce. The Hamilton group withdrew from Starling Medical College to form the Columbus Medical College (1875). The new College was first located on High Street. Sometime later a new building was constructed for its accommodation in Long Street. Its clinical outlet was the Hawkes Hospital of Mount Carmel, operated by the Sisters of the Holy Cross. To this new faculty, Howard Culbertson was elected as Professor of Ophthalmology and Otology (1876). He served in this capacity until 1881.

(To run out the skein of Columbus Medical College, upon the death of Hamilton [1892], it merged with Starling Medical College. During its separate existence, 1875 to 1892, approximately 500 students were graduated with the degree of doctor of medicine.)

Culbertson was a frequent contributor to the medical literature. While on the faculty of Columbus Medical College he proposed a simplified technique for the determination of weakness of the extraocular muscles (1877). By dividing the range of movement into four quadrants for each eye, on large cardboards, one was enabled to assign the affected muscle. He suggested a check by placing a prism with the base to the region of the involved muscle. In another paper (1883) Culbertson advanced evidence for a sequential development of glaucoma. In explanation of its pathogenesis, he favored an inflammatory process, spreading along the uveal tract to the iris with later involvement of the retina, over the neurogenic theory. Mechanically minded, he offered two devices in his special field, neither of which found general acceptance. The first related to a special spectacle frame that permitted the attachment of a second lens over the fixed or permanent one (1883). Persuasive as were his arguments for its usefulness, the frame (Fig 3) never replaced Benjamin Franklin's bifocal lens. A second device (1884), termed the prisoptometer, was an adaptation of a series of optical prisms to facilitate refraction. From an extended inquiry, its fate could not be determined. Certainly the instrument could not have had a wide acceptance.

Fig. 3—Proposed spectacle frame.



Culbertson's mechanical bent found outlets in other fields. He devised a meerschaum probe for locating bullets. In 1873 there appeared a description of an instrument for insufflating medicaments in powdered form into the uterus. He claimed good results in vaginal, uterine, and rectal disorders. His last paper concerned binocular astigmatism. It was read before the Section of Ophthalmology at the 39th Annual Meeting of the American Medical Association, Cincinnati, May 7, 1888. In addition to his personal literary activity, Culbertson was for some years an assistant editor of the *American Journal of Ophthalmology*. For 22 years he served as an examiner on the local Pension Board, in which capacity he was highly respected.

Howard Culbertson married Maria Louise Safford, daughter of Dr. Eliel T. Safford of Parkersburg, West Virginia, November 16, 1854. To this union, seven children were born. Dr. Culbertson died June 18, 1890, from "the infirmities of overwork and exposure in the service of his country," a memorialist wrote. With an obvious addiction to printer's ink, he wrote extensively and well in the standards of his day. Singularly his magnum opus was in orthopedic surgery, not ophthalmology. For years his "Excision of the Larger Joints of the Extremities" was the authoritative reference source in this field. A man of unquestionable talents, Culbertson adopted the "antiseptic principle," when many great surgeons faltered or openly obstructed the practice in this country. Culbertson was a national figure in his day, a "worker in the vineyard" who discharged every recorded responsibility with fidelity and effectiveness. His mark was left on this community by his superb record as the Officer in Charge of Harvey Hospital.

The material assistance in affording source materials for this paper is gratefully acknowledged to Dean Charles A. Doan, Dr. Jonathan Forman, Vice President Richard L. Meiling, Mr. Howard L. Culbertson and Mr. Hart F. Page. The photograph of Dr. Culbertson was supplied from the collection of the National Library of Medicine through the courtesy of Dr. Peter D. Olch.

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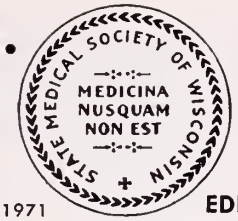
SECTION



OPHTHALMOLOGY

NOVEMBER 1971

EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

JOINS EYE CLINIC OF WAUSAU

C. F. MacCarthy, MD in July joined the Eye Clinic of Wausau for the practice of ophthalmology in association with MDs G. L. Backer, W. D. Backer, L. J. Rossman, and J. M. Hattenhauer.

Doctor MacCarthy's premedical education was obtained at the University of Detroit and Marquette University in Milwaukee. He then attended Stritch School of Medicine of Loyola University in Chicago, graduating in 1963. He took an internship at Mercy Hospital in Chicago, then entered the Navy in 1964.

Doctor MacCarthy spent four years in the Navy; in Pensacola, Fla., as a general medical officer and at the Naval Air Test Center in Patuxent River, Md., as a flight surgeon. He then took a three-year residency at the Mayo Clinic in Rochester, Minn., before moving to Wausau.

OPTOMETRY SCHOOL PLANNED IN LA CROSSE

At the Editor's request, A. Vincent Weber, associate dean, College of Letters and Science, WSU—La Crosse, submitted the following report concerning establishment of an optometry school in La Crosse.

"At the April 23, 1971, State University Board of Regents' meeting the Wisconsin State University—La Crosse submitted a preliminary report regarding the establishment of an optometry program at the La Crosse university. The preliminary report included endorsement by the Wisconsin Optometric Association that such a program be established at the Wisconsin State University—La Crosse.

"The Education Committee authorized WSU—La Crosse to conduct further studies of need and costs and to accept external funds, if available, to defray the costs of the study. The university was further directed to make a final report to the Education Committee for study prior to its making a general recommendation to the Board. The proposal as presented was to plan the development of a six-year program in optometry, including two years of preprofessional study and four years of professional study, culminating in the awarding of the professional degree, Doctor of Optometry.

"Wisconsin State University—La Crosse now is in the process of developing a final report for submission to the Board of Regents. To this end they have secured the assistance of Gordon Heath, Dean, School of Optometry, Indiana University, Bloomington, Ind. They hope the study will be completed in the not too distant future."

UW HAS WINNING EXHIBIT

An exhibit on "Retinopathy in Experimental Diabetes" by Ronald L. Engerman, PhD, Matthew D. Davis, MD, and James M. B. Bloodworth, MD won third place at the American Academy of Ophthalmology and Otolaryngology meeting in Las Vegas, Nev., September 20–24.

The exhibit illustrated the development of capillary aneurysms and other features of diabetic retinopathy in dogs made diabetic in their laboratory. Three to five years after diabetes had been produced in dogs by a single injection of Alloxan or by a brief series of growth hormone injections the animals were found to develop retinopathy and other vascular lesions identical with those of diabetes mellitus in man.

The exhibit demonstrated that the interval between the onset of the diabetes and the apparent onset of retinopathy, while surprisingly long, is perhaps not unlike that encountered with most diabetic patients.

The doctors are in the Departments of Ophthalmology and Pathology, University of Wisconsin Medical Center, Madison.

WORK WEEK OF HEALTH SPEAKER

Michael R. McCormick, MD of Waukesha addressed nurses, practical nurses, and health affiliated personnel at the Wisconsin Work Week of Health program October 20 in Milwaukee. The Work Week is sponsored annually by the State Medical Society of Wisconsin. Doctor McCormick's subject was "Vision" as it relates to the "Special Problems of the Nursing Home Patient."

UW RESIDENTS FINISH

Four residents completed their ophthalmology residency at the University of Wisconsin Medical Center August 31. Frederick Brightbill, MD has taken a one-year cornea fellowship at the University of Florida with Doctor Kaufman. Bruce Fishburn, MD has joined two other ophthalmologists in Montana. John Brooks, MD has taken over the practice of a retiring ophthalmologist in Colorado. Oksana Mensheha, MD has joined James Ferwerda, MD in Racine.

DOCTOR GALLAHER SUCCUMBS

An Appleton ophthalmologist, David M. Gallaher, MD, died August 12 in Madison. His obituary appears in this issue on page 69. □

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NEWS HIGHLIGHTS

Dr. Hoffman Heads Anesthesiologists

Philip A. Hoffman, MD,* Madison was elected president of the Wisconsin Society of Anesthesiologists at its annual fall meeting September 18–19 at The Pioneer in Oshkosh.

Other officers elected were: Frederick J. Carpenter, MD,* Wauwatosa, president-elect, and John A. Kelble, MD,* Milwaukee, treasurer.

Named to the Board of Directors were Ernest Hensehel, MD,* Milwaukee, Gregory Gallo, MD,* Waukesha, and Claude Taylor, MD,* Madison. Doctors Hensehel and Carpenter were named alternate delegates to the American Society of Anesthesiologists (ASA).

Named district director to the ASA was John W. Temple, MD* of Wauwatosa; and Gordon Garnett, MD* of Madison was named alternate director to the ASA District 24.

The Society's secretary, Ruth A. Stoerker, MD* of Madison reported that an excellent program was presented at the well attended meeting. Subjects considered were halothane hepatitis, neurolept analgesia in pediatric anesthesia, the role of oxygen and arterial gradients along with cellular effects of anesthetics, and included as speakers: John F. Nunn, MB, professor and chairman, Division of Anesthesia, Middlesex, England; C. R. Stephen, MD, Washington University, St. Louis, Mo.; John Kampine, MD,* and Richard Stewart, MD,* Medical College of Wisconsin, Milwaukee.

Dr. Pitot Named Acting Dean, UW Medical School

Henry C. Pitot, MD,* chairman of the Pathology Department of the University of Wisconsin Medical Center, has been appointed acting dean of the Medical School.

The appointment, effective October 15, followed the resignation of Peter L. Eichman, MD* who had been dean since 1965. Dr. Eichman subsequently was appointed coordinator of UW health affairs and resumed his professorship in neurology and medicine.

Dr. Pitot received his medical degree in 1955 and a PhD in biochemistry in 1959, both from Tulane University, New Orleans.

After a year as a postdoctoral fellow at the McArdle Laboratory in Madison, Dr. Pitot was appointed assistant professor of oncology and pathology in 1960. He was named associate professor in 1963 and professor in 1965.

Dr. Leslie Jones Is New President State Radiologists

Leslie Jones, MD* of Fond du Lac was installed as president of the Wisconsin Radiological Society during its 22nd annual meeting at Lake Delton September 17–19. He succeeds Harold Ibach, MD* of Milwaukee.

Other new officers are: president-elect, Andrew Crummy, MD* of Madison; vice-president, Robert Douglas, MD* of Neenah; secretary–treasurer, Marvin Hinke, MD* of Marshfield.

MDs Ibach, John Walerius* of Green Bay, and Ralph Kennedy* of Appleton were elected to the Board of Directors. Doctor Ibach also was elected to the Board of Censors.

MDs Farrell Golden* of Madison and Robert Zach* of Monroe were elected alternate counsellors to the American College of Radiology.

New active members accepted into the Society were MDs Bruce Kirkham,* presently on active duty with the US Public Health Service in New Orleans, later to locate in Eau Claire; James Combs,* Monroe; George Roggensach,* Madison; and Peter Ullrich,* Eau Claire. Dai Kap Kim, MD* of Racine was elected to associate membership.

The main guest speaker was Richard H. Greenspan, MD, professor of radiology, University of California, San Francisco, who spoke on "Pulmonary Embolism" and "Some Conditions Associated with Air Trapping."

Doctor Crummy was program chairman.

PHYSICIAN BRIEFS

Larry R. Severeid, MD

. . . has become associated with the Gundersen Clinic and La Crosse Lutheran Hospital in the Department of Otolaryngology and Maxillofacial Surgery. Dr. Severeid was born in Des Moines, Iowa, where he attended the public schools and graduated from the East High School in 1955. He attended Grand View Junior College from 1955 to 1956 and the University of Iowa, Iowa City, from 1956 to 1959. He obtained his MD degree at the University of Iowa Medical School in 1963. Dr. Severeid served his internship at the Los Angeles County General Hospital, Los Angeles, Calif., from 1963 to 1964. From 1964 to 1966 he completed his military obligation with the U. S. Navy. He fulfilled his residency training in general surgery at the University of Iowa, Iowa City, from 1966 to 1967, and comes to Gundersen Clinic upon completion of his training in otolaryngology and maxillofacial surgery at the University of Iowa, Iowa City, Iowa.

Seymour Halleck, MD*

. . . director of student health psychiatry at the University of Wisconsin and chief psychiatric consultant for the State Division of Corrections, made his debut as a columnist in the Sept. 15 issue of *The Capital Times*, a Madison daily newspaper. The column will be an exclusive, biweekly feature in which Dr. Halleck hopes to contribute a unique dimension to news writing, "by bringing his skill and experience to bear on a wide range of social and ethical problems," the *Times* reported.

Roger C. Cantwell, MD*

. . . Shawano, presented the history of medicine in Shawano County at the fall annual meeting of the Shawano County Historical Society October 18.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Steven Berman, MD

. . . Madison, has joined the staff of the Quisling Clinic. Doctor Berman graduated from Loyola University in 1965 and served his internship at Cook County Hospital, Chicago. He also served two years with the United States Public Health Service Indian Hospital at Winnebago, Neb. Doctor Berman recently completed his pediatric residency at the University of Illinois Hospital.

Joseph C. Darin, MD*

. . . Brookfield, recently was appointed vice-chairman of the Division of Surgery at the Medical College of Wisconsin, Milwaukee. He has been a member of the Medical College faculty since 1955. A 1954 graduate from the Marquette University School of Medicine, he served his internship at Columbia Hospital and was a resident at the Marquette affiliated hospitals.

Howard W. Mahaffey, MD*

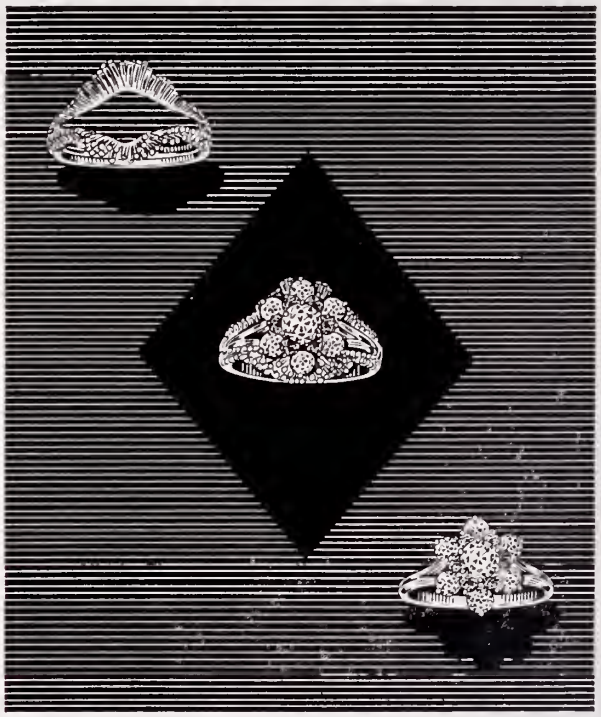
. . . Madison, recently was elected president of the executive committee and chief of the medical staff of Methodist Hospital. Other officers elected were MDs Louis F. Warrick,* Madison, vice-president, and C. W. Schmidt,* Marshall, secretary–treasurer.

John B. Hughes, MD*

. . . Oshkosh, was elected chief of staff at Mercy Medical Center for 1971–72. MDs C. I. Bowerman,* Oshkosh, and J. R. McKenzie,* Oshkosh, were named vice-president and secretary, respectively. Department head appointments include MDs W. E. Clark*, Oshkosh, chief of surgery; R. C. Hughes,* Oshkosh, chief of medicine; and R. C. Wolfgram,* Oshkosh, chief of obstetrics–gynecology.

C. A. Klasinski, MD*

. . . Stevens Point, recently presented a paper in Detroit entitled "Post Trauma Soft Tissue Salvage of the Extremities." The paper was presented before a gathering of orthopedic surgeons from various parts of the nation. Doctor Klasinski also recently returned from the Pan American Fracture Association meeting which was held in Guadalajara, Mexico.



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Dr. John M. Irvin, Monroe, Heads State Internists

John M. Irvin, MD* of Monroe was installed as president of the Wisconsin Society of Internal Medicine and the Wisconsin Section of the American College of Physicians at a meeting September 17–18 in Green Bay.

Other officers elected were: Robert C. Puestow, MD,* Manitowoc, secretary–treasurer; and Robert F. Madden, MD,* Milwaukee, president-elect.

The American College of Physicians and the Wisconsin Society of Internal Medicine held a joint scientific–educational program which involved clinical reports on diseases of the endocrine glands and metabolic disorders.

On the socio–economic side, the 150 physicians, wives, and guests heard a panel discussion on National Health Insurance. On the panel were Robert E. Durkin, vice-president of the Milwaukee County Labor Council, AFL–CIO; Malcolm Scamahorn, MD, president of the Indiana Medical Society and a spokesman for the American Medical Association's alternative proposal—Medicredit; Blaine Hibbard, MD, of Kansas City, Mo., secretary–treasurer of the American Society of Internal Medicine and a spokesman for its plan, and Rep. John Byrnes of Green Bay, a ranking Republican member of the House Ways and Means Committee which is now studying the various health care financing proposals now before Congress.

Doctor Irvin moderated the panel which in the end agreed that all were concerned about over-promising the public, particularly because of the doctor shortage. In spite of the differences between labor and the medical profession, it was generally conceded that the program had brought about worthwhile dialogue.

This annual fall meeting was planned under the direction of Herbert W. Pohle, MD* of Milwaukee, ACP Governor for Wisconsin and clinical professor of medicine at the Medical College of Wisconsin. Doctor Pohle was assisted by Addis C. Costello, MD* of Milwaukee, president of the WSIM. Doctor Irvin was chairman of the program committee.

Doctors Discuss Pediatrics and Malpractice, Wausau

About 100 pediatricians and general practitioners from three states converged September 10 in Wausau for a day-long session on pediatrics and malpractice.

The program was sponsored by the Marathon County Medical Society and hosted by Employers Insurance of Wausau.

The Marathon Society also cosponsored a visit by John C. Weaver, president of the University of Wisconsin, to Wausau on September 27. He inspected the UW Marathon Campus and delivered a speech to area physicians, university personnel, and invited guests.

Dr. Mubarak Hosts Society

Members of the Monroe County Medical Society attended a Lecture Party September 29 at the J. S. Mubarak, MD* cottage. Erik Gundersen, MD* of La Crosse showed movies on coronary bypass and Robert Green, MD* of La Crosse discussed angiography. A discussion period followed.

Renato Travelli, MD

. . . La Crosse, recently joined the department of radiology at the Gundersen Clinic and Lutheran Hospital in La Crosse. He graduated from the University of Rome Medical School in 1956 and served his internship at Union Memorial Hospital, Baltimore, Md. Doctor Travelli completed his residency training at the Albany New York Hospital, Mayo Clinic, Rochester, Minn., and the Winnipeg Children's Hospital, Manitoba, Canada. He was a staff radiologist at Holy Cross Hospital and Veterans Administration Hospital, Calgary, Alberta, Canada, and served with the U.S. Naval Reserve as a staff radiologist at St. Albans Naval Hospital, Long Island, N.Y. Before joining the Clinic, he was a staff radiologist at St. Joseph's Hospital, Milwaukee.

Simon Tan, MD

. . . West Bend, recently joined the medical staff of the West Bend Clinic. He graduated from the University of Santo Tomas, Manila, Philippines, in 1960 and interned at Deaconess Hospital in Buffalo. Further training in pediatrics was taken at Cook County Hospital, Chicago, and at Little Company of Mary in Evergreen Park, Ill.

Ronald T. Abbott, MD

. . . Dodgeville, recently joined the staff of the Dodgeville Clinic. Doctor Abbott graduated from the Glasgow University Medical School in 1956 and took postgraduate training in the Glasgow area. He previously had practiced in Canada and Turtle Lake, North Dakota.

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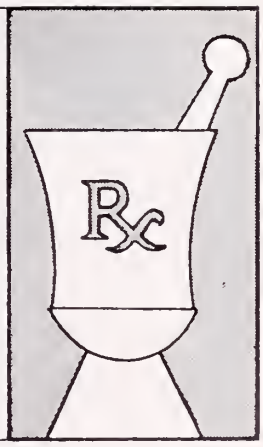

Gualberto B. Mejia, MD*

. . . Crystal Lake, recently opened his office in the Oxford Medical Clinic. He graduated from the University of Santo Tomas, Manila, Philippines, in 1956 and served his internship and residency at Carney Hospital, Boston, and the Cambridge, Mass., TB Sanatarium. Prior to opening his practice in Marquette County, he had practiced in Clinton and was on the medical staff of Beloit Memorial Hospital.

Byung Hoon Kim, MD

. . . Racine, recently became associated as a staff physician in the radiology department at St. Mary's Hospital, Racine. Doctor Kim attended Severance Medical College in Seoul, Korea, and specialized in radiology at Toronto University in Ontario, Canada. He is certified by the American Board of Radiology. Prior to joining the staff at St. Mary's Hospital, he was a member of the faculty staff at University Hospital, Chicago, and acted as consultant at Chicago's Cook County Hospital.

MDs and RNs Alerted to Congenital Syphilis at Green Bay Conference

On October 14 about 70 Green Bay area physicians and 150 nurses joined together at the Green Bay Community Service Center for an all-day conference on perinatal care and the high-risk infant.

Jointly sponsored by the Brown County Medical Society, St. Vincent Hospital, and the Community Service Center, participants heard experts in their fields describe techniques and theories concerning perinatal medicine and the problems and the care of the high-risk infants.

Don Freeman, MD, chief of obstetrics at Hennepin County General Hospital in Minneapolis, was a major speaker who discussed premature rupture of the membranes and use of oxytocics.

Another speaker, Jerold Lucey, MD, professor of pediatrics at the University of Vermont, discussed suspected sepsis in newborn infants. He advocated a complete series of tests be run on infants suspected of being infected, including examination for congenital syphilis, cystic fibrosis, and hepatitis.

He said "there is a whole generation of physicians who have never seen a case of (congenital) syphilis." He warned that it was becoming more prevalent again and urged physicians to keep it in mind.

Other speakers in the conference included Stanley Graven, MD,* Madison, co-director of the Wisconsin Perinatal Center; James Somers, psychologist at Community Service Center, and Mary Thomas, RN, head nurse at St. Vincent Hospital's neonatal intensive care unit.

Affiliate for Medical Technology Program

It was announced in October that Ripon College would affiliate with St. Agnes Hospital in Fond du Lac for a degree program in medical technology.

Under the program, the student will complete his A.B. at Ripon, taking the basic science courses needed for acceptance in an accredited medical technology program. After graduation he would spend one year as an intern at St. Agnes in the program.

MEDICAL STAFF

OWEN OTTO, M. D.
Medical Director

EUGENE B. FRANK, M. D.

THOMAS J. GORAL, M. D.

LEROY WAUCK, Ph. D.
Clinical Psychologist

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Jackson Clinic–Foundation, Madison, Presents Program

The forty-first annual fall postgraduate meeting of the Jackson Clinic and Foundation was held October 7 at the Park Motor Inn in Madison.

Sanford Mackman, MD* (general surgery) was chairman of the first part of the program which included the following speakers and their topics: Robert A. Bonebrake, MD* (internal medicine), "Acute Monarthritis;" Gordon A. Tuffli, MD* (pediatrics), "Therapy of Acute Diabetic Acidosis in Children;" Carl B. Weston, MD* (internal medicine), "Management of Ulcerative Colitis;" and Hubert V. Moss, MD* (dermatology), "Cutaneous Manifestations of Systemic Disease."

The second part of the program was chairmaned by William B. Parsons, Jr., MD* (internal medicine). It included: Eugene W. Wasylenki, MD* (otorhinolaryngology), "Modern Management of the Chronic Draining Ear;" Sanford Mackman, MD* (surgery), "Pitfalls in the Diagnosis of Metastatic Carcinoma;" and a panel discussion on "Hiatus Hernia" moderated by Louis F. Warrick, MD* (medicine); panelists: William L. Waskow, MD* (radiology); Blake E. Waterhouse, MD* (gastroenterology), Klaus D. Backwinkel, MD* (general surgery), and Allen J. Pois, MD* (cardiovascular and thoracic surgery).

The evening dinner program was given by the Madison Repertory Theater under the direction of Nancy Stearns.

CONTRIBUTIONS—CES FOUNDATION
September 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for September 1971:

Nonrestricted

Anonymous	Contribution
State Medical Society Members	Voluntary contributions of 11 MDs
State Medical Society	Memorials: D. M. Gallaher, Jr., MD, W. E. Sullivan, PhD
E. J. Nordby, MD	Memorial: W. E. Sullivan, PhD
Wisconsin Physicians Service	Memorial: James C. Fox, MD
Mr. and Mrs. E. R. Thayer, E. J. Nordby, MD	Memorial: Fred A. Risser, Sr.

Student Loans

State Medical Society Members	Voluntary contributions of 1 MD

Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 1 MD

Medical Student Summer Externship Program

Putnum Heights Clinic, S. C.—Drs. Richards, Lotz, Giffen & Raymond; D. F. Ruf, MD, F. M. Schammel, MD, William H. Hale, MD, Doris Roob, MD, Thomas M. Loescher, MD	Contributions

Dr. Grinde—Bell Account

Maurice Finley, Mrs. Edna Meudt	Contributions

Wisconsin Academy of General Practice Loan Fund

Norbert G. Bauch, MD, Robert F. Purtell, MD, Joseph S. Devitt, MD, E. L. Bernhart, MD, George V. Murphy, MD, W. D. Hamlin, MD, Paul E. Wainscott, MD, Charles Picard, MD, A. H. Stahmer, MD	Memorial: Cyrus G. Reznichek, MD

Student Loan Fund

Mr. and Mrs. Ralph Anderson, Mr. and Mrs. J. L. Lillesand, Mr. and Mrs. Marion A. Christiansen, Mr. and Mrs. LaVerne Johnson, Janet Buerki, Mr. and Mrs. Wm. Weitekamp, Mr. and Mrs. Robert Perske, Mr. and Mrs. Virgil Kuehne, Mr. and Mrs. Jon Cook, Mr. and Mrs. Daryl Steinberg, Mr. and Mrs. Vernon Sturtz, Dr. and Mrs. John T. Sprague, Mr. and Mrs. E. W. Kuenzi, Mr. and Mrs. Earl R. Thayer, Joan Pyre, C. H. Crownhart, Mrs. Marion Maul, Mrs. Thomas Nileman, Mrs. LaVonne S. Beale, Madison Ear, Nose & Throat Assoc., Ltd., E. J. Nordby, MD, Dr. and Mrs. Robin N. Allin, Odana Medical Center, S. C., Wisconsin Physicians Service, Robert B. Murphy, East Side Business Men's Assoc., State Medical Society — Memorial: Cyrus G. Reznichek, MD

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David Riese, MD*
Timoteo L. Galvez, MD

. . . Monroe, recently have joined the medical staff of St. Clare Hospital, Monroe. Doctor Riese graduated from the University of Wisconsin Medical School, served his internship in Cedar Rapids, Iowa, and had his residency at University Hospitals, Madison. Doctor Galvez graduated from the University of the East, and interned at Ramon Magsaysay Memorial Medical Center.

Stephen F. Wagner, MD

. . . Marshfield, recently joined the medical staff of the Marshfield Clinic. He graduated from the University of Wisconsin Medical School in 1965 and served his internship at St. Joseph's Hospital in Marshfield. Doctor Wagner served with the United States Army Medical Corps, and after his discharge he did residency work at the University of Cincinnati Children's Hospital before joining the Marshfield Clinic.

"Acutely Ill" Symposium Draws Tri-County Area Physicians to Oshkosh

Several hundred physicians met at the Pioneer Inn in Oshkosh October 14 for a symposium on the acutely ill patient. Speakers at the symposium represented some of the nation's leading hospital and medical colleges.

Sponsored jointly by the Fond du Lac, Winnebago, and Sheboygan county medical societies, the symposium was made possible through a grant from Lederle Laboratories, a division of American Cyanamid Company.

Area physicians on the program included the presidents of the three sponsoring county medical societies: Doctors James Jensen,* Sheboygan; George F. Meisinger,* Fond du Lac; and Paul Wainscott,* Winnebago.

Speakers and their topics included: Robert E. Condon, MD, professor and head, Department of Surgery, University of Iowa College of Medicine, Iowa City, "The Traumatic Abdomen" and "The Acute Abdomen;"

Donald W. Hastings, MD, professor of psychiatry, University of Minnesota Medical School, Minneapolis, "The Suicidal Patient;"

Isadore Dyer, MD, professor of obstetrics and gynecology, Tulane University School of Medicine; head, division of obstetrics, Charity Hospital, New Orleans, "Gynecologic Emergencies in Children and Adults" and "The Emergency Management of the Drug Influenced Newborn;"

Perry Scott MacNeal, MD, physician to Pennsylvania Hospital and Benjamin Franklin Clinic, Philadelphia, "The Unconscious Patient" and "Acute Respiratory Failure."

Residential Care Facility Opened

Watertown Memorial Hospital's former building in Watertown has been converted to a residential care facility and has been named Welbourne Hall in memory of R. P. Welbourne, MD, who practiced in Watertown for 12 years. It opened for business October 1.

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Carl B. Weston, MD*

. . . Madison, has joined the Jackson Clinic staff in the department of internal medicine. Previous to joining the Jackson Clinic, Doctor Weston was in private practice in Madison for many years. A native of Madison, Doctor Weston received his BS degree from the University of Wisconsin in 1956. He graduated from the Medical School at the University of Pennsylvania in 1960. He interned at Cook County Hospital in Chicago and then served a three-year residency in internal medicine at the University of Wisconsin Hospitals. Doctor Weston was certified by the American Board of Internal Medicine in 1967. He is an assistant clinical professor in the department of internal medicine at the University of Wisconsin Medical School.

Eugene W. Wasylenki, MD

. . . has joined the Jackson Clinic staff, Madison, in the department of otorhinolaryngology. Before

Dr. Wasylenki Dr. Weston

coming to Madison, Doctor Wasylenki served for two years with the U. S. Public Health Service Indian Medical Center at Gallup, N. M. A graduate of the University of Toronto in 1962, Doctor Wasylenki interned at Toronto Western Hospital. He served a two-year residency in general surgery at the Cleveland Clinic and a four-year residency in otorhinolaryngology at the University of Michigan. Doctor Wasylenki was certified by the American Board of Otolaryngology in 1970. He will become a member of the Wisconsin Otolaryngology Society and will be a clinical instructor in the Department of Otolaryngology at the University of Wisconsin Medical School.

Physicians Named Charter Diplomates of ABFP

. . . According to reports in Wisconsin newspapers the following physicians recently were named charter diplomates of the American Board of Family Practice; MDs John O. Grade,* Elm Grove; R. L. Hartzell,* Grantsburg; F. A. Melms* and M. J. Miech,* Menomonie; L. B. Torkelson,* Baldwin; D. L. Flogstad,* D. V. Moen,* D. J. Welter,* Shell Lake; J. T. Henningsen,* L. A. Kristensen,* Rice Lake; J. W. Weber,* New London; R. L. Holder,* Eugene Krohn,* J. H. Noble,* R. M. Thurow,* Black River Falls; M. L. Janssen,* A. R. Weihe,* Friendship; W. E. Wright,* Mondovi; J. P. Bender,* Chetek; and J. P. Keepman,* E. H. Kolner,* J. N. Moore,* B. E. Stein,* W. L. Washburn,* G. J. Derus,* and J. H. Renner, all from Madison.

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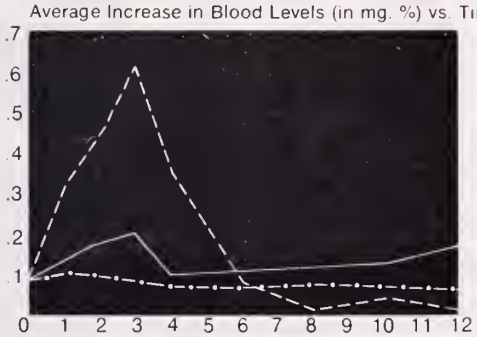

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Symposium on "Anemia" Conducted in La Crosse

More than 100 La Crosse area physicians met at the Holiday Inn in La Crosse October 20 for "A Symposium on Anemia—the Approach to Diagnosis and Management."

The symposium was sponsored by the La Crosse County Medical Society through a grant from Lederle Laboratories, a division of the American Cyanamid Company.

La Crosse physicians on the program included: Doctors Martin J. Smith;* Paul W. Phillips,* president of the La Crosse County Medical Society; and Rudolph M. Keimowitz.*

Speakers and their topics included: Theadore H. Spaet, MD, head of the hematology department, Montefiore Hospital and Medical Center, New York, and professor of medicine, Albert Einstein College of Medicine, New York City, "The Role of the Laboratory in the Diagnosis of Anemia" and "Thrombogenesis."

Victor Herbert, MD, clinical professor of pathology, College of Physicians and Surgeons, Columbia University, and medical investigator, Veterans Administration Hospital, New York City, "The Anemias of Defective Red Blood Cell Production, Emphasizing the Nutritional Deficiency Anemias."

Jane Desforges, MD, physician-in-charge, Tufts Hematology Laboratory, Boston City Hospital, Boston, "Hemolytic Anemia" and "Highlights in Pediatric Hematology."

MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF OCTOBER 1971

2 SMS Council
4 Dane County Medical Society Insurance Advisory Committee
5 Madison General Hospital Surgical Staff
5 Madison Urological Society
5 Madison Anesthesiology Society
5 Dane County Medical Society Board of Trustees
7 Madison and Area Otolaryngologists Seminar
11 Dane County Medical Society Utilization Review Plan
11 Madison Area Radiologists
12 Dane County Medical Society Annual Meeting
19 Wisconsin Work Week of Health
19 Recognition Dinner, Woman's Auxiliary to SMS
20 Wisconsin Work Week of Health (Milwaukee)
20 Board, Woman's Auxiliary to SMS
20 SMS Committee on Economic Medicine
20 Legislative Committee, Wisconsin Association of Professions
21 Wisconsin Work Week of Health—Wisconsin Physicians Service, 25th Anniversary
22 Wisconsin Work Week of Health (Wausau and Oshkosh)
23 SMS Council
23 Special Session, SMS House of Delegates
26 Operating Committee, MEDHIC
27 Executive and Legislative Committees, SMS Section on Ophthalmology
28 SMS Maternal Mortality Study Committee

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Milwaukee County Hospital Expands Radiology Services

Two years of extensive expansion and remodeling of the diagnostic radiology section of Milwaukee County General Hospital (MCGH) ended September 11 with an open house.

MCGH is the principal teaching hospital of the Medical College of Wisconsin (MCW). Its renovation was financed by Milwaukee County.

New equipment and facilities of the diagnostic area "make our radiology services on a par with other medical school teaching hospitals in the country," said James Youker, MD, professor and chairman of the MCGH and MCW integrated Division of Radiology.

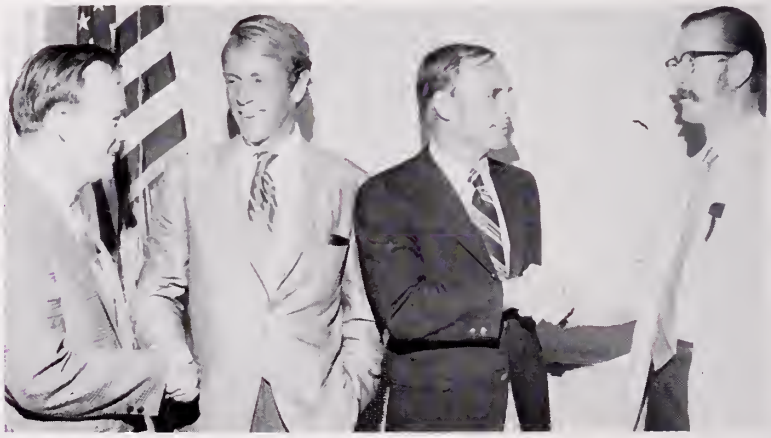
"We are able to serve our patients rapidly in a pleasing setting," said Gerard Scanlon, MD,* chief of diagnosis and a professor of radiology. Dr. Scanlon played a major role in the diagnostic expansion and remodeling.

UW Radiologic Technology School Ranks in Top Five

This year's graduates of University of Wisconsin's School of Radiologic Technology ranked in the top one percent on the American Registry of Radiologic Technologists' examination with a class average score of 90.6 percent.

In making the announcement, John H. Juhl, MD,* Director of the School and Chairman of University Hospitals Radiology Department, said, "Of the 18 University Hospitals' students taking the examination, 14 scored between 90 and 95 percent on this national examination which is given to graduates of all training programs approved by the American Medical Association."

As indicated by the results of the examination as published by the American Registry of Radiologic Technologists, University Hospitals' school ranks as one of the top five in more than 1,000 approved programs in the United States.



OFFICERS OF THE WINNEBAGO COUNTY MEDICAL SOCIETY exchanged handshakes in congratulation following election of new officers at the Society's annual meeting September 2 in Menasha. They are (l to r): Paul Wainscott, MD,* Menasha, president; Gordon Hardie, MD,* Neenah, president-elect; William Roberts, MD,* Oshkosh, secretary; and George Arndt, MD,* Neenah, past secretary. (Photo courtesy NEENAH–MENASHA DAILY NORTHWESTERN) □

OBITUARIES

Henry N. Bucksdorf, MD, 79, Lyndon Station, died Apr. 24, 1971, in Marshfield.

Born on Apr. 30, 1891, in Burlington, Ia., Doctor Bucksdorf graduated from St. Louis College of Physicians and Surgeons, St. Louis, Mo., in 1921 and served his internship in Missouri. His residency was taken at Deaconess Hospital, Chicago, in 1921. He had practiced in Whitehall, Blair, and Stoughton, Wisconsin, and moved to Lyndon Station in 1947.

David M. Gallaher, Jr., MD, 46, Appleton eye specialist, died Aug. 12, 1971, in Madison.

Born on March 30, 1925, in Appleton, Doctor Gallaher graduated from Northwestern University Medical School, Chicago, in 1949 and served his internship at Wesley Memorial Hospital in Chicago. His residency was taken at Northwestern Medical School and University of Illinois Eye and Ear Infirmary before starting practice in Appleton in 1953. He was on the medical staffs of Appleton Memorial and St. Elizabeth hospitals.

He was a member of the Outagamie County Medical Society, State Medical Society of Wisconsin, and American Medical Association.

Surviving are his mother, Mrs. David M. Gallaher, Sr., Appleton, and a sister, Dr. Marian E. Gallaher of the Los Angeles Children's Hospital.

Cyrus G. Reznichek, MD, 66, a founder of the East Madison Clinic and a prominent Madison general practitioner for over 35 years, died Sept. 7, 1971, in Madison.

Deeply concerned about the role of the family physician and the future direction of medical students, Doctor Reznichek devoted his life to improving the delivery and quality of medical care.

Doctor Reznichek was instrumental in the development of Wisconsin Physicians Service (WPS), the Blue Shield health insurance program of the State Medical Society of Wisconsin. For over 20 years he served on the Society's Commission on Medical Care Plans which directs the operation of WPS. He also was a consultant on Medicare, the government program administered in Wisconsin by WPS.

For many years he was the state advisor to the Student American Medical Association and in this capacity was a trusted counselor of University of Wisconsin medical students.

Born on Dec. 23, 1904, in Antigo, Doctor Reznichek graduated from Northwestern University Medical School in 1932 and served his internship at Cleveland City Hospital, Ohio. He practiced for a short time in Antigo and in 1935 came to Madison where he practiced until his death.

Doctor Reznichek served on the medical staffs of St. Marys and Madison General hospitals and taught physiology courses to nurses in both hospitals. In 1955 he helped establish the East Madison Clinic which has become a major medical care facility on Madison's east side.

For 15 years Doctor Reznichek served on the Madison Board of Health and was its president in 1961. A civic leader as well as a medical leader, he was chairman of Citizens for Better Government.

During Doctor Reznichek's presidency of the Dane County Medical Society in 1951, he helped the State Medical Society develop the first code for medical-press relations in the state.

He was active in a number of committees of the Dane County and State Medical societies, including the State Society's Division on Vision.

Doctor Reznichek helped in the establishment of the Madison and Wisconsin Academies of General Practice and served as president in both. He was named by the American Academy of General Practice to the American Medical Association to serve on the National Task Force on Personnel Training and Utilization for National and Emergency Care.

Surviving are his widow, the former Sara Zanna, and a daughter, Joan, and two sons, Doctors Robert and Richard.

George M. Sargeant, MD, 68, Sturgeon Bay, died Sept. 9, 1971, in Sturgeon Bay.

Born on Dec. 21, 1902, in Long Prairie, Minn., he graduated from Marquette University School of Medicine in 1935 and served his internship at Milwaukee County General Hospital. Doctor Sargeant practiced in Prairie du Chien from 1939–1945 when he joined the Baldwin Clinic in Baldwin, Wis. He retired from practice in 1959.

He was a member of the Pierce–St. Croix County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are one daughter, Mrs. Jon (Grace) Muggli, Sartell, Minn., and one son, Dr. James Sargeant, Woodruff, Wis.

Mabel G. Masten, MD, 73, Dixon, Ill., died Sept. 14, 1971, in Council Bluffs, Iowa.

Born on Dec. 29, 1897, in Mineral Point, Wis., Doctor Masten graduated from Rush Medical School, Chicago, in 1925 and completed her internship and residency at University Hospitals, Madison. She had been associated with University Hospitals for 29 years and became chairman of the Neuropsychiatry Department in 1944. Doctor Masten left Madison in 1955 to join the staff of the Veterans Administration in Miami, Fla. In 1971, she received the Emeritus Faculty Award from the University of Wisconsin Alumni Medical Association as the first woman intern, the first woman resident, and the first woman appointed to the full-time staff of the University of Wisconsin Medical School.

Surviving is a brother, Harold, Palm Beach, Fla.

Robert M. Kass, MD, 47, Eau Claire, died Sept. 26, 1971, in Eau Claire.

Born on Sept. 9, 1924, in East Dubuque, Ill., Doctor Kass graduated from St Louis University School of Medicine in 1953 and completed his internship and residency in pediatrics at Milwaukee County General Hospital. He had been associated with the Midelfort Clinic in Eau Claire for seven years and was on the medical staff of Sacred Heart and Luther hospitals. Prior to joining the Clinic, he had practiced in Wausau. Doctor Kass served with the United States Navy during World War II.

He was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, and American Medical Association.

Surviving are his widow, Phyllis; two sons, Robert, Jr., and Thomas; and one daughter, Nancy, Eau Claire. □

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MEMBERSHIP REPORT AS OF SEPTEMBER 15, 1971

continued from October issue

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Sholtes, Clause A., 30 Gulf Breeze Drive South, Port Richey, Fla. 33568
Slamer, James R., 4569 North Teutonia Ave., Milwaukee 53209
Sorenson, Robert I., 1055 Highland Dr., Elm Grove 53122
Spence, Clarence H., N A S, Warminster, Pa. 18974
Stafford, Richard B., 59 Racine St., Menasha 54952
Stilp, Lyall C., II, 510 Doctors Ct., Oshkosh 54901
Weisfeld, Samuel G., 4625 North Woodburn St., Milwaukee 53211

DEATHS

Gallaher, David M., Jr., Outagamie County, Aug. 12, 1971
Case, Kenneth C., nonmember, Aug. 24, 1971
Menne, Frank R., nonmember, Aug. 25, 1971
Reznichek, Cyrus G., Dane County, Sept. 7, 1971
Sullivan, W. E., PhD, honorary member

MEMBERSHIP REPORT AS OF OCTOBER 15, 1971

NEW MEMBERS

Ayengar, Shanta, 400 East Thomas St., Wausau 54401
Bhattacharyya, Sisir K., 630 South Central Ave., Marshfield 54449
Buie, Thomas E., Jr., 3715 Cliffside Dr., La Crosse 54601
Ficke, Albert J., 2211 Stout Rd., P. O. Box 337, Menmonie 54751
Fitz, Frederick W., 515 South Barstow St., Eau Claire 54701
Hartman, Bruce H., 10 Sheboygan St., Fond du Lac 54935
Horn, Elsa B., 282 North National Ave., Fond du Lac 54935
Kader, Nabil M. A., 212 South 11th St., La Crosse 54601
Lee, Peter U., 1146 Grant St., Beloit 53511
Lu, Albert T., 745—15th Ave., Union Grove 53182
Mahler, John H., Room 405, 20 South Park St., Madison 53715
Miller, Charles H., III, 1836 South Ave., La Crosse 54601
Miranda, Warren L., 401A East Forest St., Marshfield 54449
Roberts, Thomas N., 1836 South Ave., La Crosse 54601
Roy, Michel Yves, 630 South Central Ave., Marshfield 54449
Severeid, Larry R., 1836 South Ave., La Crosse 54601
Terman, James W., 1836 South Ave., La Crosse 54601
Travelli, Renato, 1836 South Ave., La Crosse 54601
Wasylenki, Eugene W., 30 South Henry St., Madison 53703

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Beffel, John M., 16112 Selva Dr., San Diego, Calif. 92128
Bernas, Alex A., 1024 East Colfax Pl., Whitefish Bay 53217
Braun, James E., 8700 West Wisconsin Ave., Milwaukee 53226
Brooks, John R., 1001—2nd St., West, Ashland 54806
Buckley, Clarence H., Mobile Home Park, Sarasota Fla. 33578
Edwards, John S., 202 South Park St., Madison 53715
Esser, John H., 208 East Wisconsin Ave., Milwaukee 53203
Fernandez, Pasqual B., 706 East Wisconsin Ave., Appleton 54911
Flynn, Richard T., 5000 West National Ave., Wood 53193
Fosdal, Frederick A., 2700 Marshall Ct., Madison 53705
Foseid, Oscar F., R. R. #1, Black Earth 53515
Gjud, Alexander M., 12765 West Hickory Ct., Orchard View, New Berlin 53151
Gomilla, Severino G., P. O. Box 384, Appleton 54911
Graham, Albert P., 225 County Club Drive, Largo, Fla. 33540
Gregorio, Fernando Q., 3265 Town Crier Ct., Lamplighter Park, Brookfield 53005
Gregorski, Robert F., 1101 Shore Line Ct., Dunlop, Ill. 61525
Haque, Inam ul, P. O. Box H., Winnebago 54985
Holt, Stephen H., 11942—47th Ave., Kenosha 53140
Jones, Richard J., 80 Sheboygan St., Fond du Lac 54935
Katz, Richard H., 3640 Sepulveda Blvd., Los Angeles, Calif. 90034
Keller, Theodore A., P. O. Box 427, W180 N7950 Town Hall Rd., Menomonee Falls 53051
Kraft, John W., Washoe Medical Center, Reno, Nev. 89502
Kuban, Donald J., 2900 West Oklahoma Ave., Milwaukee 53215
Larsen, John R., 300 East Reed Ave., Manitowoc 54220
Love, Robert G., Lansing, Ia. 52151
Martens, Thomas J., 1120 NW Fernwood, Corvallis, Ore. 97330
Mautz, William T., 204 Skyline Dr., Eau Claire 54701
McCormick, Glen E., 890 Elm Grove Rd., Elm Grove 53122
McGill, James W., 1718 Hammond Ave., Superior 54881
McLean, Zarah G., 2936 North 3rd St., Milwaukee 53212
Nelson, Wallace L., Box 359-F, Route 1, Long Cove Rd., Waupaca 54981
O'Loughlin, Peter D., R. R. #1, Box 221A, Necedah 54646
Olson, Marvin H., University of Texas Medical Branch, Galveston, Tex. 77550
Philbin, Daniel M., 32 Fruit St., Boston, Mass. 02114
Pick, Daniel M., P. O. Box 522, Manitowoc 54220
Qui, Felipe L., 2151 Crittenden, Beloit 53511
Randolph, William C., 300 East Reed Ave., Manitowoc 54220
Roisum, Bryant H., 30 Winchester Circle, Salisbury, N. C. 28144
Rosmann, Herman K., 209 Fuller Lane, Winnetka, Ill. 60093
Santilli, Robert J., 1643 A Shenandoah Rd., Fort Belvoir, Va. 22060
Savaglio, Vincent P., 6530 Sheridan Rd., Kenosha 53140
Schacht, Edmund W., 1 Deepwood Dr., Racine 53402
Schiebler, John C., 3152 South 35th St., La Crosse 54601
Sheehan, Edward T., 710 North Water St., Room 951, Milwaukee 53202
Singshisuk, Sompong, 1326 South 76th St., Milwaukee 53214
Small, James T., Jr., 904 Tenny Ave., Waukesha 53186
Sorenson, Robert I., 9205 West Center St., Milwaukee 53215
Tasche, John A., 3350 South Osprey Ave., No. 110A, Sarasota, Fla. 33579
Thomas, Preston W., 7815 West Wisconsin Ave., Milwaukee 53213
Thompson, Frederic A., 725 American Ave., Wauwatosa 53186
Voet, Raymond K., 5901 West Brown Deer Road, Milwaukee 53223
Weber, Carl J., 3515 North 10th St., Sheboygan 53081
Weston, Carl B., 30 South Henry St., Madison 53703
Weston, Frank L., 166 Lakewood Blvd., Madison 53704
Wiesen, Richard L., 4305 Cherokee Dr., Brookfield 53005
Windeck, James L., 127 West Central St., Chippewa Falls 54729
Wyner, Stanley F., P. O. Box 4158, Madison 53711

DEATHS

Sargeant, George M., Pierce–St. Croix County, Sept. 9, 1971
Masten, Mabel G., nonmember, Sept 14, 1971
Diamond, Carl O., Milwaukee County, Sept. 17, 1971
Kass, Robert M., Eau Claire–Dunn–Pepin County, Sept. 26, 1971
Kroyer, Theodore J., Walworth County, Sept. 28, 1971
Ruskin, Benjamin A., Milwaukee County, Sept. 28, 1971 □

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trends

The Wisconsin Regional Medical Program, Inc.

NOVEMBER, 1971

WRMP Receives $1.5 Million Award For New and Continuing Health Programs

Regional Advisory Group Given More Autonomy In Dispensing Grants

The Wisconsin Regional Medical Program received an award of $1.5 million for programming during 1971-72.

The award was announced by Dr. Harold Margulies, Director, Regional Medical Programs Service, Washington, D.C., in a letter to Dr. John S. Hirschboeck, WRMP Coordinator.

Dr. Margulies also noted that approval had been given WRMP for an additional three years of operation in the Wisconsin Region to help improve the health care delivery system through collaboration and cooperation of providers and agencies.

Besides being notified of the above actions, Dr. Hirschboeck was also notified that all monies dispersed for projects and programs need be approved by WRMP's Regional Advisory Group.

". . . the Program has demonstrated that it has the machinery, expertise and local autonomy to successfully and prudently utilize this mechanism to improve the health care services within the region," Dr. Margulies said. In addition, "core staff has demonstrated excellent leadership and competence in working with both providers and consumers of health services as well as the many agencies . . ."

"The comments of Dr. Margulies of Regional Medical Programs Service and the application review team are appreciated," Dr. Hirschboeck said. "This kind of authority and responsibility in dispensing funds in the Wisconsin Region is an indication, I think, of the credibility of the volunteers — providers and consumers — and the staff in the WRMP organization."

T. A. Duckworth, WRMP President and Vice President and Secretary Employers Insurance of Wausau, said the approval of the grant appears to have given WRMP the credibility it deserves.

"It's amazing how fast things change," Duckworth said. "Not too long ago a number of people were questioning the viability of

(Continued on Page 3)

Dr. Paul Tracy Joins WRMP As Associate Coordinator

Dr. Paul C. Tracy, a Park Ridge, Illinois, pediatrician since 1947, has joined the WRMP staff as Associate Coordinator for Program Development and Evaluation.

The announcement was made by Dr. John S. Hirschboeck, WRMP Coordinator.

As Associate Coordinator for Program Development and Evaluation, Dr. Tracy will be responsible for the supervision of the program development and evaluation staff as well as maintaining collaborative arrangements with the assistant coordinators within the two medical schools in the Wisconsin Region.

A graduate of the Loyola University School of Medicine, Dr. Tracy is on the staff of several hospitals in the Chicago area, most recently attached to Lutheran General Hospital, Park Ridge, Resurrection Hospital and Children's memorial Hospital, Chicago. He has been very active in public education activities relating to health as well as taking an active role in various community-related organizations. He is a fellow of the American Academy of Pediatrics and a past president of the Chicago Pediatric Society.

Dr. Paul C. Tracy

14 Named To Advisory Group

Fourteen Wisconsin health providers and consumers have been appointed to top committee posts of the Wisconsin Regional Medical Program (WRMP).

The announcement was made by Dr. John S. Hirschboeck, WRMP Coordinator.

The fourteen appointees to WRMP's Regional Advisory Group will be responsible for dispensing approximately $1.5 million annually for health programs in the Wisconsin region.

Named to the Committee were: George E. Collentine, Jr., M.D., Northpoint Medical Group, Milwaukee; David S. Neugent, Vice President-Marketing, The Wisconsin Blue Cross Plan, Milwaukee; James E. Youker, M.D., Chairman, Department of Radiology, Medical College of Wisconsin, Milwaukee; David A. Scott, Sr., Executive Director, Cream City Neighborhood Health Program, Inc., Milwaukee.

Also named were: Fred J. Ansfield, M.D., University Hospitals, Madison; Paul F. Fleer, M.Ed., Health Planning Council, Madison; Vincent F. Otis, Acting Director, Bureau of Comprehensive Health Planning, Division of Health, Madison; Joseph M. Lubitz, M.D., Memorial Hospital, Oconomowoc; William R. Morgan, Administrator, Lakeland Hospital, Elkorn; William W. Grover, Jr., M.D., Bonduel Clinic, Bonduel; Dean A. Emanuel, M.D., Marshfield Clinic, Marshfield; J. C. Banks, Executive Director, West Central Wisconsin Community Action Agency, Menomonie; William L. Blockstein, Ph.D., University of Wisconsin Extension, Madison; Miss Marie J. Zimmer, Ph.D., Wisconsin Nurses Association.

The 50 members of the committee work in liaison with 200 hospitals, 4,000 physicians, 16,000 nurses, 2,000 dentists and various allied health personnel, groups and consumers in seeking ways to improve health care delivery.

The Syniatrist

By John S. Hirschboeck, M.D.
Coordinator, Wisconsin Regional Medical Program

There are now more than two hundred categories of workers in health care system, and the list continues to grow. Demands for n health service along with the specialization of functions which is requ by the new technologies used in medical and hospital care are ero relationships long established among the health professions. Form this functional relationship was subtended by the physician or sur and the nurse. What was a simple and forthright collaboration amo few individuals is now beset by complications arising out of role definit licensure regulations, jurisdictional controls, professional fence build and the semantic implications in nomenclature and titles. Attempts being made to restructure roles in the health professions. These eff should be supported. WRMP's project "Nurse Utilization: A Pat Care Systems Project" is one example of this. Fortunately the pro personnel have not proposed any new titles for hospital employees. WR will soon sponsor another project entitled "New Roles for the Health fessions — The Expanded Role of the Nurse".

The so-called "physicians assistant" or P.A. is, perhaps, the most troversial recent addition to the health care system. His title and his sponsibility are the subject of much debate. As P.A.'s increase in num and diversity, their legal status comes up for consideration in many s legislatures. Are P.A.'s to become the equivalent of the Russian Feldsc or are they to be restricted to purely specialized technical tasks suc applying casts or assisting in the operating room?

Although a redefinition of roles and titles is very desirable, it is doub whether agreement can be achieved easily among the established fessions. It is worthwhile, however, to consider some suggestions for a nomenclature for the health professions. SYNIATRIST is such a (Syn signifying "along with" and iatric pertaining to "physician").[1] O first reaction is to oppose the introduction of yet another title. On other hand, Dr. Silver's suggestion has much broader implications and open the way to a complete reevaluation of the roles of the health fessions in the health care system. His suggestion is immediately appealing than the introduction of a variety of suggested new titles s as KORMAN, MEDEX, OSLER, PINEL, AND CRUZER.[2]

It seems obvious that high level diplomacy within the health profess is necessary to prevent what could deteriorate into a dog and cat f over titles and roles. WRMP can and, perhaps, should take the leader to develop productive models of interprofessional relationships as we m hopefully into new and better ways of providing health care. Dr. Silv approach is one which deserves consideration.

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(1) JAMA, September 6, 1971, Henry K. Silver, M.D.
(2) JAMA, September 6, 1971, Smith et al.
JSH-9/16/71

)r. Lawton Outlines Results ıf Task Force Public Hearings

In the future, hospitals will be-ne health centers, more com-ınity oriented than what they are the present time.

The prediction came from Dr. n R. Lawton, President of the ırshfield Clinic, Marshfield, and ce Chairman of the Governor's sk Force on Health in a recent k to hospital public information rsonnel from throughout the Re-ın.

"Hospitals will become health ıters as well as illness centers, ysicians will be practicing near ese health centers to avoid dupli-ion of services and equipment," . Lawton said. "But to achieve s is going to be awfully, awfully ɔensive. However, in the long ı, it will result in a less ex-ısive, improved quality of patient e which is one of the priorities Wisconsin and the nation."

Dr. Lawton was referring to the ablishment of Health Mainte-nce Organizations (HMO) which, en made available on a regional sis, is expected to improve patient e through the more efficient use personnel, equipment and facil-es.

The prediction is also the result a series of public hearings held oughout the state by the Gover-r's Task Force.

"The Task Force completed its blic hearings with a meeting in inelander," he continued. "As a ult of these meetings, we can etty much put our finger on the eds and wants of the consumer d provider to help improve the stem. Because of the length of ıe in office and the priority he s given to health on a Regional sis, Governor Lucey, I am sure, l see, to the best of his ability, ıt the recommendations of the sk Force are implemented."

The recurring items as a result of public hearings include:

Maldistribution and shortage of doctors. Most apparent in the minority group areas of Wisconsin — especially the American Indians in the north and the Spanish Americans and Blacks in the Greater Milwaukee area. Not enough "people doctors". There is a demand for the family doctor or physician assistant.

— Physician fees are high and the cost of a hospital bed is going out of sight, although the quality of care is generally good.

— Public is pouring millions of dollars over the counter for "faddism" — counter patents and dangerous cults like chiropractic.

— Health planning to date, which has been done basically by providers, is becoming more and more unacceptable. Providers, consumers and hospitals must work together to improve the delivery system.

"I don't think I'm letting anything out of the bag," Dr. Lawton said. "None of this is news. It's a matter of asking the public, the user and provider, openly aware of these needs and the need for someone to grab a handle on the kettle and do something with it. This is what, I feel, the Governor's Task Force will achieve."

Dr. Ben Lawton

John E. Linster

Linster Appointed To Commission

John E. Linster, a member of WRMP Regional Advisory Group and Senior Vice President, Employers Insurance of Wausau, Wausau, has been appointed to the Commission on Medical Malpractice. The appointment was made by Elliot Richardson, Secretary, HEW.

Continued from Page 1

$1.5 Million Award

WRMP. With the approval of the grant and the change in direction indicated by Dr. Margulies, Regional Medical Programs might well be near the hub of the health care delivery system in the very near future."

Judge Rodney Lee Young, Chairman of the Regional Advisory Group, noted that the action taken by Washington gives the Regional Advisory Group authority and responsibility never exercised in the past.

"The ability to grab hold of the problem at the local level represents an honest and sincere appraisal of the program at the national level," Judge Young said.

"I can't help but feel that the dedication and sincerity of our Advisory Group played a major role in the action taken by Washington," he continued. "We have demonstrated that our actions and dedication in the past assure those concerned that we utilize every resource available to us before deciding on issues and programs which are in the best interests of the health and well-being of both the provider and consumer in the State of Wisconsin."

Clark Joins WRMP As Subregional Rep

Charles G. Clark, retired manager of Abbott Laboratories' Far East branches, has joined WRMP as Subregional Representative for Northern Wisconsin.

The announcement was made by Dr. John S. Hirschboeck, WRMP Coordinator.

In his position, Clark, of Ladysmith, will work closely with health facilities in an effort to establish a closer link between the rural communities in northern Wisconsin and the heavily populated Milwaukee-Madison areas.

Spending most of his years in northern Illinois, he moved to Ladysmith after his retirement two years ago. In his position with Abbott, he was responsible for operations in Japan, Taipei, India, Pakistan, Phillipines, Malaysia, Singapore, Australia, New Zealand and Hong Kong.

Physician Dial Access Begins Operation On Self-Sufficient Basis

One of the first programs put into operation by the Wisconsin Regional Medical Program (WRMP) has become a self-sufficient operation.

The Physician's Dial Access program, which received nationwide attention, especially during the past two years, was made available to physicians on an individual subscriber basis beginning September 1.

More than 33,000 calls have been placed by physicians since the program was put into operation through support of WRMP in January, 1968. During the past year, more than 3,800 duplicate tapes have been made and sold to regional medical programs and medical schools throughout the country and Canada.

According to Dr. John S. Hirschboeck, WRMP Coordinator, the Physician Dial Access program is a good example of how WRMP funds are used to help make a program, which has merit, become a very important educational tool and eventually evolve into a self-supporting program without losing its credibility or importance to the target group it serves.

The charge for the service is $25 annually. This includes access to more than 500 physician and 80 nursing tapes, unlimited calls and availability on a 24-hour, 365-day basis. The tapes are updated as the need arises at no additional charge.

Physicians in the Wisconsin Region interested in subscribing to the service should write: Dr. Sigurd Sivertson, WRMP Assistant Program Coordinator-University of Wisconsin, 610 N. Walnut St., Madison, Wisconsin 53706.

Hornback Named Head of Nurse Dial Access

May S. Hornback, R.N., Acting Chairman of the Department of Nursing, University Extension, Madison, has been named project director of the Nursing Dial Access Project.

She succeeds Mrs. Signe S. Cooper, R.N., who has accepted a position to study and develop a plan for continuing education in nursing in the north central, five-state area of the United States. The study is an 18 month project under the Division of Health Manpower Education, HEW.

Trends is published quarterly The Wisconsin Regional Med Program, Inc., 110 E. Wiscor Ave., Milwaukee, Wis. 53202. A cles for publication can be sent the above address in care of Di tor, Public Information.

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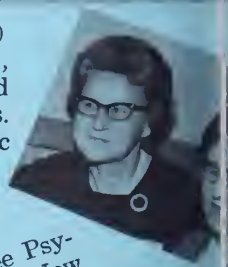
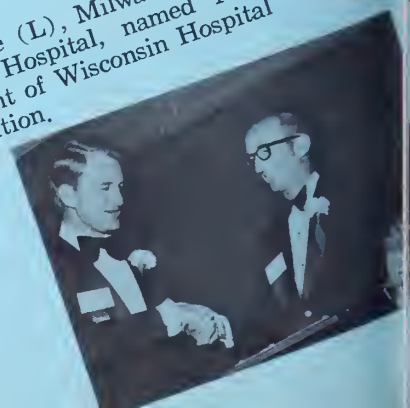
T. A. Duckworth, (L) WRMP Pres. and V.P., Employers Insurance of Wausau, receives Wis. Hosp. Assn's "Award of Merit" from WHA'S Past President Ted Besser, Hudson.

Sr. M. Regina (R) St. Joe's Hosp., River Falls, elected President of Wis. Conf. of Catholic Hospitals.



Dean Roe (L), Milwaukee Psychiatric Hospital, named New President of Wisconsin Hospital Association.



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POSTGRADUATE COURSES

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1972 WISCONSIN

Jan. 9: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "The First 60 Minutes After Pulmonary Embolus" and "Selection and Plan for Anticoagulant Therapy," at St. Marys Hospital Medical Center, Madison.

Feb. 17: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Immediate Care of Acute Stroke" and "Current Management of Diabetic Keto-acidosis and Coma," at St. Marys Hospital Medical Center, Madison.

Feb. 18–19: Annual Meeting, Wisconsin Otolaryngological Society, SMS Building, Madison.

Mar. 15: In-Depth Teaching Program of State Medical Society of Wisconsin—CES Foundation, including lectures on "Current Management of Rh ve Pregnant Patient Before and After Delivery" and "Current Management of the Newborn Who Becomes Jaundiced in the First 24 Hours," at St. Marys Hospital Medical Center, Madison.

Mar. 23–25: *Learning Disabilities in Children,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Mar. 31–Apr. 1: Midwest Chapter, College of Sports Medicine Meeting, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 13–15: *Advances in Pediatric Radiology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

Apr. 14–15: Annual Meeting, Wisconsin Urological Society, Edgewater Hotel, Madison.

Apr. 24–26: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 9–11: Annual Meeting, State Medical Society of Wisconsin, Milwaukee.

May 11–13: Applied Genetics for the Clinician Conference, Wisconsin Center, Madison. Info: Dr. Fritz A. Bach, Associate Professor of Medicine Genetics, 418 Genetics, University of Wisconsin, Madison, Wis. 53706.

June 8–10: *Recent Progress in Hematology,* Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 16–17: North Central Dialysis and Transplant Conference, Department of Postgraduate Medical Education, University of Wisconsin, Madison.

June 19–23: Mid-America Hospital Medical Staff Conference, co-sponsored by the Medical Society of Milwaukee County and the Hospital Council of the Greater Milwaukee Area, The Abbey, Fontana.

1972 NEIGHBORING STATES

Feb. 15–18: Four-day refresher course for family practitioner of medicine, University of Iowa Health Center. Info: Director, Office of Medical Education, Office of the Dean, University of Iowa, Iowa City, Iowa 52240.

1972 AMA

Sept. 11–12: Congress on Occupational Health, Drake Hotel, Chicago, Ill.

1972 OTHERS

Jan. 23–29: *Concepts of Soft Tissue Surgery,* Mercy Hospital, Pittsburgh, Pa., sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $400. Contact: John T. Dickinson, MD, DSc, G-2 MD Bldg., 1501 Locust St., Pittsburgh, Pa. 15219.

Feb. 5–12: Annual scientific meeting, Far Western Medical Association, Aspen, Colo. Info: A. J. Krukas, MD, Secretary–Treasurer, Suite 416, 16542 Ventura Blvd., Encino, Calif. 91316.

Feb. 6–11: *Rhinoplasty Workshop in Toronto,* University of Toronto Department of Post Graduate Medicine, Department of Otolaryngology, Department of Anatomy, Division of Instructional Media, sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $300, residents—$150. Contact: Mrs. Caroline Flynn, Division of Post Graduate Medicine, U. of Toronto, Toronto, Ontario, Canada.

Feb. 21–23: Scientific Sessions Seminar, Ala Moana Hotel, Honolulu, Hawaii. Info: Scientific Sessions, 217 Alexander St., Rochester, N. Y. 14607.

Feb. 23–26: *Surgery of the Hand,* University of Colorado School of Medicine, Denver.

Feb. 26–Mar. 4: Twelfth Congress of the Pan-Pacific Surgical Association, Hilton Hawaiian Village Hotel, Honolulu, Hawaii. Info: Pan-Pacific Surgical Association, 236 Alexander Young Building, Honolulu, Hawaii 96813.

Feb. 27–Mar. 3: *Workshop in Advanced Rhinoplasty,* Department of Otolaryngology, Baylor University College of Medicine, Houston, Tex., sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Registration fee: $500. Contact: Dr. William K. Wright, Director, Suite 508 Hermann Professional Bldg., Texas Medical Center, Houston, Tex. 77025.

Feb. 28–Mar. 2: *Modern Concepts in Acute and Chronic Cardiopulmonary Care—Newborn, Adult,* American College of Chest Physicians and others, Steamboat Springs, Colo.

Feb. 28–Mar. 3: Winter meeting, American Society of Contemporary Ophthalmology, Diplomat Hotel, Hollywood, Fla. Info: John G. Bellows, MD, Secretary, 30 North Michigan Ave., Chicago, Ill. 60602; tel. 312/236–4673.

Mar. 1–4: *Medical Malpractice: A Legal Course for Doctors,* Americana Hotel, Bal Harbour, Fla. Info: IV Medical/Legal Institute, University of Miami Law Center, Coral Gables, Fla. 33124.

Mar. 13–16: *Maxillofacial Trauma,* Department of Otolaryngology and Maxillofacial Surgery, University of Cincinnati Medical Center, Cincinnati, Ohio, sponsored by American Academy of Facial Plastic and Reconstructive Surgery, Inc. Tuition: $400. Registrar: Miss Debby Adkins, Office of CONMED, Room 114, College of Medicine, University of Cincinnati, Cincinnati, Ohio 45219.

April 21: Symposium on Infectious Diseases, American Academy of General Practice, Battenfeld Auditorium, Kansas City, Kan.

Apr. 23–29: Ninth Interamerican Congress of Cardiology, San Francisco, Calif.

May 12–13: Clinical–Professional Meeting, American College of Legal Medicine, Americana Hotel, Miami Beach, Fla. Info: ACLM, 1340 N. Astor St., Suite 1201, Chicago, Ill. 60610.

Sept. 25–28: Annual scientific assembly, American Academy of General Practice, New York Coliseum, New York, N.Y.

Sept. 27–29: *Seventh National Cancer Conference,* American Cancer Society and National Cancer Institute, Baltimore Hotel, Los Angeles, Calif. Indo: Sidney L. Arje, MD, Coordinator, Seventh Nat'l Cancer Conf. % American Cancer Society, 219 East 42nd Street, New Yory, N. Y., 10017.

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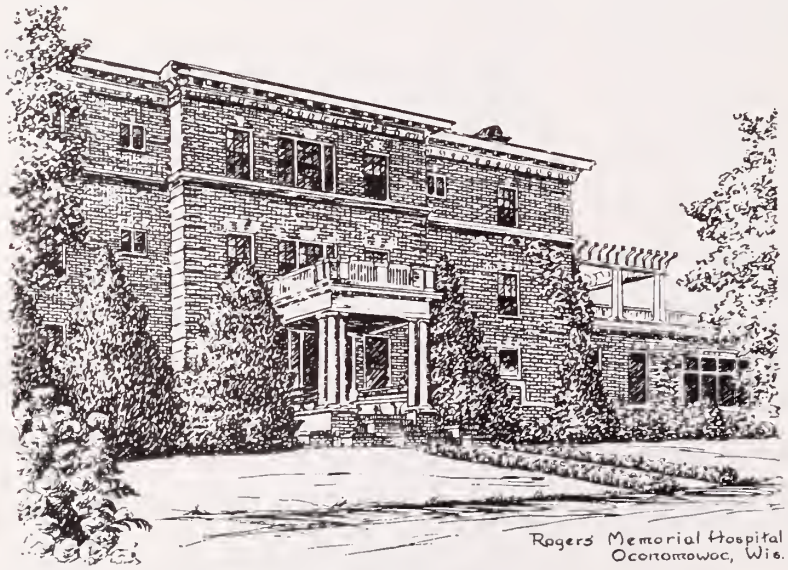

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1972 INTERNATIONAL

Mar. 4–11: Scientific meeting, Far Western Medical Association, Zermatt, Switzerland, followed by a week at Val D'Isere, France. Info: A. J. Krukas, MD, Secretary–Treasurer, Suite 416, 16542 Ventura Blvd., Encino, Calif. 91316.

1973 WISCONSIN

May 7–9: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 15–17: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1973 AMA

Sept. 17–18: Congress on Occupational Health, Ben Franklin Hotel, Philadelphia, Pa.

1974 WISCONSIN

May 6–8: Annual Meeting, Wisconsin State Dental Society, Milwaukee.

May 14–16: Annual Meeting, State Medical Society of Wisconsin, Milwaukee Auditorium and Hotel Sheraton–Schroeder, Milwaukee.

1974 INTERNATIONAL

Oct. 20–26: XIth International Cancer Congress, Florence, Italy.

For listing of other meetings see the **Journal of the American Medical Association.**

Refresher Course for Family Physicians—Milwaukee

The Medical College of Wisconsin will hold the Second Annual Winter Refresher Course for Family Physicians January 27–30 at the Pfister Hotel and Tower in Milwaukee. The four-day course, cosponsored by the Wisconsin Academy of Family Physicians and its Milwaukee chapter, will include review and discussion of medical topics of particular interest to family physicians and a practice exam for doctors intending to take the family practice board examination.

Lawrence V. Perlman, MD, Assistant Professor of Medicine at MCW and the course director for the sessions, will be assisted by other members of the MCW faculty in presenting the topics. Evening sessions will feature a "Meet the Professor" format, with cases presented by fellows or residents in the various areas for discussion by the professor with participants.

The course is approved for 24 hours of prescribed credit by the American Academy of Family Physicians.

Registration is limited to 100 participants and will close on December 15. For further information on registration and tuition, and for a copy of the program, contact Mrs. Elaine Gamerdinger, Continuing Education Department, Medical College of Wisconsin, 561 North 15th Street, Milwaukee, Wis. 53233.

In-Depth Teaching Program—Madison

The third in-depth teaching program of the State Medical Society and University of Wisconsin Medical Center will be presented January 19 in Madison at St. Mary's Hospital Medical Center.

Group ward rounds and demonstrations will be conducted in the morning, followed by a luncheon, and an afternoon of lectures and discussions.

George E. Magnin, MD, Associate Clinical Professor of Medicine and Richard D. Sautter, MD, Clinical Instructor in Surgery, will lecture on "The First 60 Minutes after Pulmonary Embolus." Donald R. Korst, MD, Associate Professor of Medicine, will discuss "Selection and Plan for Anticoagulant Therapy."

continued on page 13

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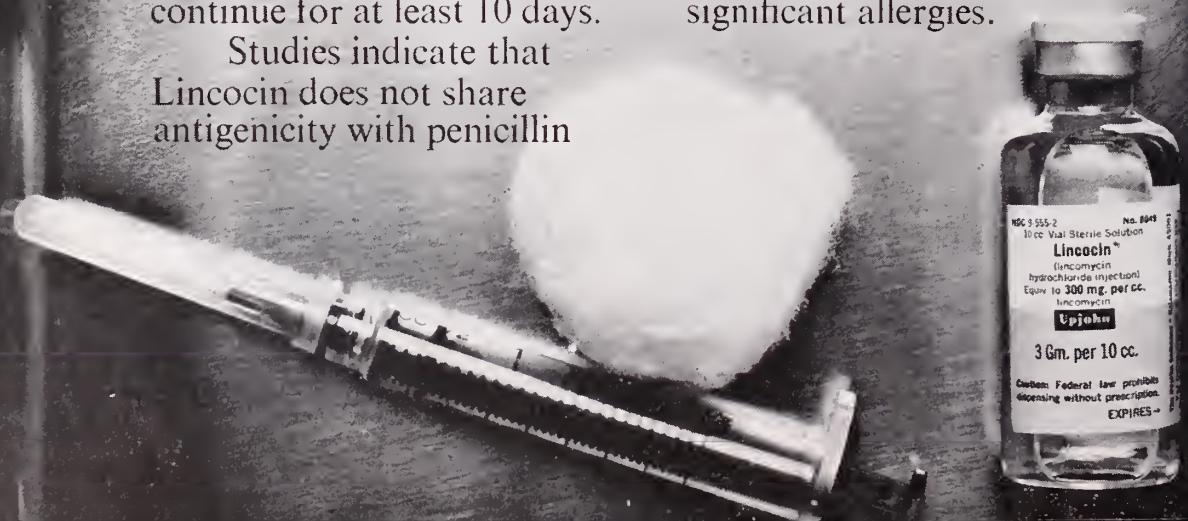

Participation has already been arranged through pre-registration.

This program is one in a series of five. Other remaining programs are scheduled for February 17 and March 15. Details appeared in the October issue.

Applied Genetics for Clinician—Madison

The Applied Genetics for the Clinician Conference is scheduled for May 11–13 at the Wisconsin Center in Madison. The conference objective is to present in concentrated fashion the current status of genetics in medical practice and discussion of future possibilities, both immediate and remote, which are appearing.

To meet these ends, the conference will include discussion and demonstration of:

. . . Basic genetic principles for the clinician
. . . Foundations of genetic counseling
. . . Newer methodologies and applications of cytogenetics
. . . Prenatal genetics and *in vitro* assays of mutations in human cells
. . . Transplantation genetics
. . . Current and future possibilities of genetic intervention.

The conference is structured to allow free exchange of views between registrants and faculty, as well as the opportunities for problem solving and discussion of case material. The faculty will include both members of the laboratory of medical genetics and visiting faculty.

Conference planners believe it will be of value to family practitioners, internists, pediatricians, obstetricians, and those health professions whose interests are in the fields of hereditary and family disease, congenital abnormality, mental retardation, and inborn errors of metabolism.

Further info: Dr. Fritz Bach, Associate Professor of Medicine Genetics, 418 Genetics, University of Wisconsin, Madison, Wis. 53706.

Female Reproductive Physiology—Rockford

On March 16–17 the Rockford Memorial Hospital of Rockford, Illinois, will present a symposium entitled, "The Practical Approach to Female Reproductive Physiology."

This session will emphasize the basic science, as well as clinical concepts in reproductive endocrinology and infertility. Faculty will be made up of four members of the Baylor College of Medicine.

For information write: Dr. Ronald Burmeister, 2300 North Rockton Ave., Rockford, Ill. 61103.

DEPARTMENT OF POSTGRADUATE MEDICAL EDUCATION

University of Wisconsin—Madison

1972

March 23–25	*Learning Disabilities in Children*
March 31–April 1	*Midwest Chapter, College of Sports Medicine Meeting*
April 13–15	*Advances in Pediatric Radiology*
May 11–12	*Genetics for the Clinician*
June 16–17	*North Central Dialysis and Transplant Conference*
June 8–10	*Recent Progress in Hematology*

INFO: Thomas C. Meyer, MD, Chairman, 575 WARF Office Bldg., Madison, Wis. 53705; tel. 608/2623–2850.

Sports Medicine Meeting—Philadelphia

The American College of Sports Medicine has announced the tentative program for its 19th Annual Meeting to be held May 1–3, 1972, in Philadelphia, Pa.

For additional information contact: Donald E. Herrmann, Exec. Secy., ACSM, 1440 Monroe Street, Madison, Wis. 53706.

New Orleans Medical Assembly—March 6–9

When The New Orleans Graduate Medical Assembly convenes again this year, it will be for its 35th annual meeting, to be held March 6–9, 1972, at The Fairmont Roosevelt Hotel. Twenty distinguished speakers, well known for their various specialties, have been selected to report on medical advancements in their areas. Medical motion pictures, roundtable luncheons, a clinicopathologic conference, and entertainment for wives will add interest to the program. A special pre-meeting symposium by Lederle Laboratories is planned for Sunday March 5 entitled "Our Polluted Environment—Its Problems for the Clinician."

This program is acceptable for twenty-two (22) prescribed hours and eight (8) elective hours by the American Academy of Family Physicians. For further information write to The New Orleans Graduate Medical Assembly, 1430 Tulane Ave., New Orleans, La. 70112.

25th National Conference

on Rural Health

March 16–17, 1972

St. Francis Hotel, San Francisco

Theme: Partnership for Rural Health Care Development

Purpose: To explore new needs and report on new developments in:

- Rural Community Planning for Health System Development
- The Health Team in Rural Health Systems
- Health Science Schools and Rural Health Manpower
- Resource Development for Rural Health Systems
- Programming Rural Health Services for All People
- The California State Health Plan and Rural Health
- Successful Community Health Programs
- Rural Community Health Programs
- Rural Development—An Answer to Rural Health
- Research in Rural Health Services
- The Future and Rural Health

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STATE MEDICAL SOCIETY OF WISCONSIN

OFFICIAL CALL for Scientific Exhibits

1972 ANNUAL MEETING, MILWAUKEE

May 9–11

Sheraton–Schroeder Hotel—Scientific Exhibits and Program

★

The Commission on Scientific Medicine is desirous of knowing which members of the State Medical Society are interested in presenting scientific exhibits in connection with the 1972 Annual Meeting. The exhibits will be located in **Milwaukee.**

To facilitate arrangements for the proper location of the scientific exhibits, individuals and organizations desiring space in the 1972 meeting are requested to file an application before *Feb. 1, 1972,* giving a full description of the exhibit, the amount of space required, and the basic equipment which will be needed. *Space assignments will be made as exhibits approved by Commission on Scientific Medicine.*

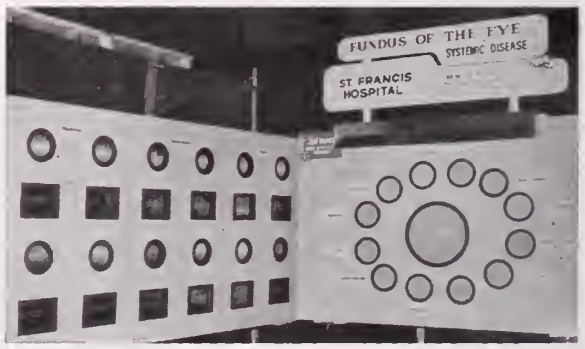
In-state exhibitors will have the following facilities provided by the State Medical Society: Fiberglass draping and identifying sign.

The exhibitor must furnish: Transportation costs of exhibit, special radiologic viewing boxes, special chrome furniture or rugs, electrical connections, shelving or tables, and special lighting equipment (rented through Badger Exposition Service, Inc., Milwaukee, on form to be furnished all exhibits scheduled).

Booths for scientific exhibits will have fiberglass background, 8′ in height, and 8′ fiberglass side dividers (such as is shown in illustration at right).

No exhibit may exceed a height of 7′ from the floor.

Counters (3′ high and 20″ wide) or tables (30″ high and 3′ wide) are available for viewboxes or displays to be raised above floor level.



Those interested in providing an exhibit are required to file an application and a full description of the exhibit. **DEADLINE FOR APPLICATIONS: FEB. 1, 1972.**

Address your communications to:

ROBERT G. WOCHOS, MD
Director of Scientific Exhibits
% State Medical Society of Wisconsin
Box 1109
Madison Wis. 53701

USE FORM ON FOLLOWING PAGE →

PRESIDENT'S PAGE

Christmas Thoughts

WITH THE CHRISTMAS SEASON at hand, I would like to take this occasion to personally wish each and every member of the medical profession a Merry Christmas and a Happy New Year. May the true spirit of Christmas be a dominant force in our lives. An innocent child born in a manger who grew to serve and inspire people should somehow parallel the dedication of medicine to relieve suffering and minister to the health and well being of all people.

We all realize that the Big Santa cannot and will not by legislation meet all the needs and problems of medical care, for only the skilled hands of the physician can administer to the emotional and physical needs of people.

At this season of joy and reflection let us all rededicate our lives to the service of mankind through the knowledge and skill of our profession and the guidance of the Great Physician.

G. A. Behnke M.D.

G. A. BEHNKE, MD

the WISCONSIN MEDICAL JOURNAL
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EDITORIALS

RAYMOND HEADLEE, MD, *Editorial Director*

The Medical Mystique

LIKE THE NOW INFAMOUS "Feminine Mystique" the medical mystique has served us well, has many points in its favor—even if occasionally misunderstood, and need not interfere with other perhaps more important things that physicians, and in the analogy —women can do.

The term "mystique" is used because it implies a consistent point of view about ourselves and a point of view which comes across to the public as if we held a certain charm or special power. It is really like the "Feminine Mystique" which implies that the woman is both highly desirable because of superior and not too clearly defined qualities, yet feared after all. The doctor has for centuries assumed a kind of charisma, even a life-or-death posture. But he has been no more than a participant in the assumption of such a role. Patients and public alike have, until the last five years, insisted that the doctor take this position. As must always occur, such imbalance between two categories of persons produces ambivalence. We have been respected, but snipped at. We have been loved, but hated. And we have been seen as powerful magicians, but frauds.

It is now timely to examine some of the details of this medical mystique, since some of the glitter seems a bit dulled and our public is pressing for a more human face to medicine. The mystique itself seems to consist of a central core of belief about medical effectiveness. "Good old doctor" always knows best, and this has been our slogan chanted by all in chorus, patient, family, and friends. In private practice this takes the form of hard work, careful attention to details of diagnosis and treatment, conscientious participation in hospital affairs, and community involvement, at least to the extent of formal membership in nonmedical groups. It often includes attendance at refresher courses and/or professional meetings. These are all the things a proper physician, at least of my generation, need do. In academe the identical principles underly our professional actions. We strive for excellence; we keep up to date with latest techniques or drugs; we organize ourselves nationally in proper groups; and we teach others, imparting not only our knowledge but also our standards to young men who aspire to the medical model. As with men in private practice, the academician is haunted by literal and continual excellence. Having bridged both worlds I see the near identical mystique to which both town and gown aspire. Now to merely aspire to perfection is no crime, and no neurosis either. But what happens to us, AND TO OUR PUBLIC IMAGE, when our standards preclude extension of service to masses of people. The existing medical schools are built upon this medical mystique and professors really cannot more than double their output of new physicians

under the present system, no matter how hard they work. They are bound by their own pursuit of standards, intermingled with the necessity for an appearance of "research" activity. From this intellectual posture they cannot but disdain any dilution of what they assume to be standards, and deride those who would teach aught but pure science.

Sadly our public has become dissatisfied with our pretences of total standards and of total social concern. They do not believe our editorials protesting the medical mystique. They are impressed with new discoveries all right and for the most part with the energies and the intelligence of the average practitioner.

Our first lapse from the public favor has been the wresting from us of financial planning. Sure, the AMA plan has a chance but it is now but one plan of many, and even it is suspect because of historically ineffectual, albeit vituperous opposition to medicare (tagged in public eye as greed, no matter what we say or how often we explain). Our second lapse has been our curious struggle, now waning, on medical assistant programs. Curious, because the physician can only gain help while being relieved of detail by most proposed paramedical programs. Our third and most serious lapse is our failure to grasp the possibility that our tight clinging to the medical mystique may have kept us blind to the fact that an overwhelming percentage of citizens cannot reach a physician, simply because there are not enough doctors to go around. This is likely more true in our urban areas, but nonetheless it is this issue with which we are face to face, whether we choose to admit it. Just how the body politic will manage is not yet clear, even to it. It may be by some program of direct clinical training of MDs as in the bill to establish a national medical school, or academy, similar to West Point and Annapolis, which, I understand, has already passed the House of Representatives. It may take the form of extended clinical training, already experimentally begun both in Indianapolis and in Gainsville, utilizing nontraditional medical centers and utilizing active practitioners throughout the state. As mentioned in previous editorials, Wisconsin now uses seven of its out-state physicians in this manner. Or, of course, someone may devise further alternatives. Unless we admit into our thinking the need to meet these social issues, we will be left with our mystique, our purely medical skills, and not much else. I am trying in these pages, to see that we do not end up like the aging lady whose mystique has been her major investment in charm and in mascara, and who is losing one and doubling the other. What are we doing? —RH

A Renaissance Man Has Passed Our Way

Although I did not know him personally, William D. Stovall has forever and a day imprinted his energy, his integrity, and his breadth of interest upon the medical scene, especially of Wisconsin. His list of doings, sayings, and writings is long and covers much of both the scientific and the compassionate aspects of medicine. These were celebrated in this *Journal* in October 1961, in a dedicated festschrift, and will be recounted by others in issues to follow. From my view it is heartening to know such a man can live, and can live for eighty-four years. I believe that marks of his efforts will be seen for years to come. —RH

Doctor Stovall—He Gave

To the State Medical Society, one of his many first loves, he gave his idealism and a great amount of energy for over half a century.

To the Cancer Society he gave a corps of inspired volunteers, an undreamed of goal, and continuous enthusiasm for a worthy health cause.

To Wisconsin women he gave new hope in the fight against uterine cancer with his training program for cytologists.

To all Wisconsin citizens he gave inspiring direction for the state's public welfare and social service system.

To thousands of medical students and, in turn, thousands of Wisconsin physicians he gave his teaching—imprinting his own deep appreciation for human compassion upon those who were seeking the basic scientific knowledge of medical practice.

There is hardly a physician—yes, hardly a person in Wisconsin to whom Doctor Stovall hasn't given much. His gifts to the people of Wisconsin can best be acknowledged by the ultimate compliment: Our imitation of his example. —ERT

Another Criticism of Physicians: Reply

PHYSICIANS HAVE BEEN CRITICIZED for having little interest in the "spiritual life" of their patients. These critics state that "man is a physical, emotional, and spiritual being" and that in illness, all aspects of his being must be treated. No doubt this is a just criticism, for medicine first does emphasize the treatment of physical disease. Furthermore, it has not been until the recent past that physicians have recognized the interrelationships of physical and emotional disease. The spiritual aspects of human personality as they apply in disease and health have been little understood and taught by physicians, medical societies, and medical schools.

Now there can be a response to this criticism. The American Medical Association has a Committee on Medicine and Religion. Composed of clergymen and physicians, this committee has encouraged the development of similar committees in the state and county medical societies. At the present time all state medical societies have committees on medicine and religion and most county medical societies have appointed similar committees.

In 1968 the Council of the State Medical Society of Wisconsin appointed its first Committee on Medicine and Religion. The major goal of this committee has been to encourage medical and religious activities at the county medical society level. Hopefully this will lead to increasing dialogue between physicians and clergymen. The program of medicine and religion for the State Medical Society represents a new thrust for the society. It reaffirms what has been known since the earlier years of history. Priest and physician often must work together to cure the patient.

The Committee on Medicine and Religion of our State Medical Society is anxious to promote activities throughout the state, and welcomes the support and interest of all physicians and clergymen.—JOHN O. SIMENSTAD, MD, Osceola. □

SERVICES TO PHYSICIANS AND THE PUBLIC

from the

PUBLIC INFORMATION DEPARTMENT OF THE STATE MEDICAL SOCIETY

The following services are provided to member physicians and the general public, under the direction of the Commission on Health Information—a standing committee of the Council. For the most part they are designed to assist the physician in preparing for participation in health education events such as speeches to non-medical audiences, or to provide factual health information directly to the general public. Address requests, or have your patients write: Public Information Department, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

LOAN PACKETS

Reference materials are provided, on a loan basis, on such topics as Fluoridation, Establishing a Practice, Health Fads and Fallacies, Alcoholism, Drug Abuse, Health Careers, and numerous others.

FILM SERVICE

An index of films, suitable for both medical and non-medical audiences, is maintained by the Society. Please be as specific as possible concerning the desired topic. Since the Society does not maintain a film library and all films must be ordered from another source, two weeks notice is desirable. Cost normally involves only return postage, however in some cases there is a rental or service charge to be paid by the recipient.

HEALTH CAREERS MATERIALS

Materials on careers in medicine are available as references for physicians participating in Career Days and leaflets are available in quantity for distribution to groups. Reference materials on careers ancillary to medicine, and sources of loans and scholarships are also available.

HEALTH EDUCATION LITERATURE

Single pamphlets are available on a wide range of topics for individuals seeking factual information on health.

MOUTH-TO-MOUTH BREATHING AND CLOSED CHEST CARDIAC MASSAGE

Films and a demonstration manikin are available for special programs on mouth-to-mouth breathing and closed chest cardiac massage. The latter topic is considered appropriate for physicians, nurses, policemen, firemen and rescue personnel, and requires supervision of a physician trained in the technique.

SPEAKERS SERVICE

While it is normally desirable to have a local physician fulfill speaking engagements in his community, speakers are available on the state level where a special topic or audience size makes it desirable.

MINUTES—SPECIAL MEETING OF THE COUNCIL

MADISON, OCTOBER 2, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 2:00 p.m. at the Society.

Voting members present: Doctors Schrank, Huth, Nordby, Davenport, Edwards, Smejkal, Dettmann, Mauthe, Heinen, Lewis, Egan, Foley; President Behnke and Speaker Nereim.

Others: President-elect Purtell; Drs. W. G. Richards and E. A. Birge, pathology; S. A. Spicuzza, physical medicine; Leslie Jones, radiology; Phillip Hoffman, anesthesiology; George Handy, State Health Officer; Messrs. Thayer, Koenig, Maroney, Brower, Reynolds, Murphy, Crownhart; Misses Cordts and Pyre.

2. Purpose of Meeting

Chairman Nordby stated that the purpose of the special Council meeting was to receive information on the health care legislation which will be the subject of a special session of the House of Delegates on October 23 (per vote of the Council in a telephone conference on September 29); to provide guidelines to staff on informing the membership of the issues and consider whether the Council wished to make any recommendation; and to advise staff in event there should be legislative action on either certificate of need or employment of physicians prior to October 23.

Memorandum Report of Council Meeting Held via Telephone Conference Call, Wednesday, September 29, 1971, 10 p.m.

Voting Members of the Council participating in the conference: Doctors Schrank, Galgano, Huth, Nordby, Davenport, Edwards, Smejkal, Dettmann, Mauthe, Rohde, Heinen, Lewis, Manz, Egan, Foley, Schmidt, Meyer, and President Behnke.

Others: President-elect Purtell; Messrs. Thayer, Koenig, Maroney, Murphy, Kluwin, and Miss Pyre.

Mr. Thayer informed the Council of developments during the week concerning anticipated early drafting and introduction by Rep. Czerwinski of legislation to repeal part or all of the Wisconsin Statute on "Fee splitting between physicians and others" for the purpose of permitting employment of physicians on salary by hospitals and health maintenance organizations. He also outlined a new version of the "Certificate of Need" proposal which had been introduced by the same Representative by way of Substitute Amendment 1 to Assembly Bill 1104. This has implications for health care far beyond those of the original bill which the Council and House of Delegates had voted to oppose.

He stated that this health care legislation involves basic policy considerations for the Society and indicated that a special session of the Council or House of Delegates was necessary to guide the staff.

On motion of Doctors Schmidt–Galgano, carried unanimously, the Council called a special meeting of the House of Delegates on October 23 to consider these matters, the earliest date possible under the Constitution.

The Council also agreed to hold a special meeting on Saturday, October 2, to consider interim steps to be taken, and asked that representatives of the medical specialties who work under contract with hospitals be asked to attend.

EARL R. THAYER
Secretary

3. Review and Discussion of Legislative Proposals

Mr. Thayer reviewed the status of the two legislative proposals —employment of physicians and certificate of need—and made a statement as to present-day public attitudes and influences which affect the legislative climate in which they will be considered.

As to each proposal, separate presentations were made by Messrs. Maroney, Murphy, Reynolds and Brower, setting forth arguments made by proponents and opponents.

Open discussion of the two issues followed. It was concluded that the Secretary should proceed to send background information on the issues to the House of Delegates, the membership, and the Council, and that the Council would meet again at 9:00 a.m. on the 23rd to consider whether specific recommendations should be presented the House for action.

Staff was advised that if in the course of the legislative process it is necessary to state a position on these bills prior to the House meeting . . .

(a) As to certificate of need, they should state the existing policy of the House of Delegates in opposition to certificate of need legislation, which was reaffirmed on motion of Doctors Smejkal–Heinen, carried.

(b) As to employment of physicians, the position of the Society in reference to Bill 129, A. of 1959 should be explained, the specialties should be called on, and the fact of the special session to review the matter should be made known.

4. Annual Meeting Dates

The Council was advised that definite word had just been received that the Milwaukee Auditorium would not be available to the Society for a May annual meeting.

On motion of Doctors Schrank–Smejkal, carried, the Council agreed to the week of April 9 for the 1972 annual meeting.

(NOTE: Because of commitments already made for May, the original dates of May 9–11 were subsequently approved by poll of the Executive Committee, utilizing the Sheraton–Schroeder for the scientific program and exhibits, and the Holiday Inn Central for the House of Delegates.)

5. Adjournment—4:45 p.m.

Respectfully submitted:
EARL R. THAYER
Secretary

Approved:
E. J. NORDBY, MD
Chairman

SUPPORT YOUR FOUNDATION

It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

Minutes of Special Council Meeting

MADISON, OCTOBER 23, 1971

1. Call to Order and Roll Call

The meeting was called to order by Chairman Nordby at 9:05 a.m. at the Society.

Voting members present: Doctors Schrank, Galgano, Nordby, Davenport, Edwards, Dettmann, Mauthe, Rohde, Heinen, Lewis, Manz, Doyle, Egan, Meyer, President Behnke and Speaker Nereim.

Others: Vice-speaker Hamlin; Doctors Bell, Galasinski, Carlson, Russell, Kief; Messrs. Thayer, Koenig, Doran, Reynolds, Maroney, McIntyre, Lockerbie, Murphy, Kluwin, Horton, Crownhart; Mmes. Angell and Anderson; Miss Pyre.

2. Approval of Minutes

On motion of Doctors Davenport–Dettmann, carried, the Council approved minutes as distributed of the special meeting on October 2 and memorandum report of the meeting held September 29 via telephone conference when it was decided to call a special meeting of the House of Delegates.

3. Report of President Behnke

Doctor Behnke read a proposed three-part program concerning legislative contacts and planning and requested approval of the Council to his presenting it to the House of Delegates.

On motion of Doctors Edwards–Rohde, carried, the Council approved its presentation to the House, the details to be worked out later.

4. Four Health Care Legislative Issues

The Council had received material prepared by staff and consultants in consultation with Chairman Nordby, setting forth facts and alternative positions that could be taken as to each of the four legislative proposals.

(This was printed in its entirety, together with action taken by the House of Delegates, in the November GREEN SHEET section of the *Journal*. These minutes record only Council motions to forward the alternatives to the House with its recommendations as to the position to be taken.)

A. Employment of Physicians by Hospitals—AB 1391

On motion of Doctors Schrank–Galgano, carried, the Council recommended alternative 3 to recognize that in limited situations and under proper safeguards the employment of physicians by hospitals may be beneficial in providing health care for the people of Wisconsin; and amended one of the enumerated "safeguards" to read, "requiring that contracts of employment be approved and supervised by the hospital's medical staff and be filed with the State Medical Examining Board.

B. Certificate of Need—AB 1104 and Substitute Amendment 1

On motion of Doctors Dettmann–Davenport, carried, the Council recommended alternative 3 to recognize the concept of certificate of need for licensed institutions providing inpatient care.

C. Generic Prescribing and Dispensing—AB 206 and Substitute Amendment 1

On motion of Doctors Edwards–Manz, carried, the Council recommended that neither the bill nor substitute be approved, but that alternative 3 be supported calling for a study committee to analyze generic name prescribing and dispensing, the question of therapeutic equivalency, and whether cost reductions would result, for report to the Legislature.

D. Title 19 Medicaid Benefits—AB 1387

On motion of Doctors Schrank–Davenport, carried, the Council recommended alternative 2 supporting greater flexibility in authority of the State Department of Health and Social Services to administer or contract for these benefits.

5. 1972 Annual Meeting Arrangements

On motion of Doctors Behnke–Edwards, carried, the Council confirmed action of the Executive Committee in reverting to May dates for the Annual Meeting without using the Milwaukee Auditorium.

6. Executive Committee Meeting with Wisconsin Hospital Association

Mr. Thayer reported the request received from Mr. Von Ehren for a joint meeting of Executive Committees on legislative issues on November 18 or 19. The Executive Committee of the Council agreed to meet the morning of the 18th.

7. Menominee County Health Care

On motion of Doctors Dettmann–Edwards, carried, the Council adopted the following resolution which is self-explanatory:

WHEREAS, The State Medical Society in 1964 conducted a lengthy and thorough analysis of health and health care among the Menominee Indians including a survey of every family in Menominee County; and

WHEREAS, The analysis resulted in a series of important recommendations to the health professions, the public, and state and local governments, many of which have yet to be implemented; and

WHEREAS, The State Medical Society's House of Delegates in May 1970 called upon the state's medical schools to develop a model service and medical training project providing ambulatory health service for the 2800 residents of Menominee County; and

WHEREAS, The Society recognizes that although fine hospital and medical care are for most Menominee County residents only 15–20 minutes away, the more serious of the continuing health problems for the people of that county have several possible solutions; now, therefore, be it

Resolved, That the State Medical Society appeal to Governor Lucey to establish a special Menominee Health Care Commission composed of representatives of the families living in that county, officials of the county government and state agencies with potential ability to aid in the solution of health care problems including transportation, the area health officer, representatives of the two medical schools, the State Medical Society and county societies in the area, for the purpose of implementing already recognized solutions for existing problems and such new proposals as may seem feasible; and be it further

Resolved, That the Society appeal to the USPHS to locate a full-time National Health Service Corps physician in Menominee County, Wisconsin, at the earliest possible date; and be it finally

Resolved, That if there is not assurance that such a physician can be provided by November 15 or shortly thereafter, the State Medical Society seek to enlist volunteer physicians to staff a temporary clinic in the county on a part-time but regular basis until more permanent arrangements can be made.

8. Councilor Resignation and Election

Doctor Egan reported on behalf of the Milwaukee delegation that Doctor Sullivan had submitted his resignation as councilor for health reasons, and that Paul LaBissoniere, MD, had been nominated to replace him.

On motion of Doctor Dettmann, seconded and carried, Doctor LaBissoniere was elected to the Council.

On motion of Doctors Egan–Mauthe, carried, the Council asked that a letter of appreciation for his service on the Council be sent to Doctor Sullivan.

9. Adjournment

The meeting adjourned at 10:15 a m.

Respectfully submitted:
EARL R. THAYER
Secretary

Approved:
E. J. NORDBY, M.D.
Chairman

LETTERS

Letters to the Editor are welcomed and will be published for informative and educational purposes as space permits. As with other material which is submitted for publication, all letters will be subject to the usual editing. Address all correspondence to: THE EDITOR, WISCONSIN MEDICAL JOURNAL, *Box 1109, Madison, Wisconsin 53701.*

A PUBLIC HEALTH ADVISOR'S VIEW

Concerned About VD Reporting by Physicians

TO THE EDITOR: I was reading over our monthly narrative report from our district personnel, and thought that the following message might be of interest to Wisconsin physicians. Mr. Pfrang is one of our young VD investigators under Dr. Grant Skinner of the Section on VD Control. He is assigned to the Green Bay area. This article is very precise in the analysis of the local program.

GEORGE H. HANDY, MD
State Health Officer

THIS MONTH I would like to cover what is probably the biggest single obstacle to effective VD control and epidemiology in my area. That is, of course, the reporting to the State by private physicians of all diagnosed cases of the venereal diseases. We feel we have a pretty effective apparatus set up here in Wisconsin to confidentially interview these reported patients and follow up their named sex contacts for diagnosis and treatment. We also feel that if this apparatus is fully utilized, it will greatly reduce the incidence of VD in the State. Unfortunately this apparatus cannot be set in motion until a physician's report of venereal disease form is sent to the Division of Health with the name of a diagnosed patient on it.

If J. S. McKenzie–Pollock the Director of the Venereal Disease Division of the ASHA is to be believed, four out of five cases of venereal disease in the U.S. are seen by private physicians and only one in nine of these cases is reported to the public health authority. If we can apply these statistics intact to the State, we are talking about 72% of all VD in Wisconsin being completely unknown to us. There were 7727 *reported* cases of gonorrhea in the State last year, so you can draw your own conclusions.

When I talk to people in local health departments and nursing services, they admit concern over the VD problem. They are as aware of the statistics as I am and yet these figures are only a statistical probability—an educated guess if you will. The actual problem could be much more or less critical than the figures lead us to believe.

When a local health officer or supervising nurse expresses a need for a VD clinic or VD information in the schools, they can only be guessing that such a need exists because for most areas of the State there is no concrete statistical proof to support them. I do not want to seem as though I am laying the whole blame on the private physician. We are talking about a grey area here.

On the one hand the law states unequivocally that all cases of VD will be reported to the Division of Health but many doctors have told me honestly and sincerely that they feel by complying with the law, they are committing a serious breach of medical ethics and the doctor–patient relationship. They are right in that if information on one of their patients became public, it could possibly jeopardize the person's standing in the community and even his job and ultimately his whole standard of life.

They are wrong when they make the assumption that we will be any less confidential or professional than they are with this information or that we have any less than the most critical need for it if we are going to be able to make any progress toward controlling VD.

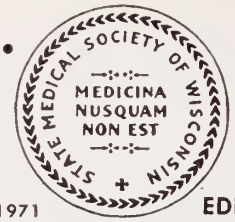
I guess the problem ultimately comes down to the attitudes of all of us as the general public. How many of us if we were being treated for VD wouldn't expect the doctor as a matter of course to refrain from reporting it because of "who we are?" What would be our reaction if we discovered a friend, neighbor, co-worker, even a member of our own family, had VD? Would we look at it as an easily treated and only conditionally communicable infection with serious consequences only to the untreated patient or would we see it as a social stigma and a moral judgment on the person infected?

Have we, the people, caused to be enacted a law that we really do not want to be enforced—or at least only in certain cases? Are our private physicians doing any more of this than what actually we expect of them in their handling of venereal disease? Is the solution to educate the physician or to educate the public or both and if so, how do we do it?

I do not know the answers to these questions. I know that doctors do not like to treat venereal disease because these questions are unanswered. I know that people with VD go untreated because these questions are unanswered. I know that we probably will not be able to reduce VD until the questions are answered and I know that it is my job, along with everybody else involved in VD control, to find the answers. I just thought you might like to know. If anyone reading this has any ideas, I would appreciate hearing from you.

MICHAEL M. PFRANG
Public Health Advisor

SECTION



OPHTHALMOLOGY

DECEMBER 1971 EDITOR: James C. Allen, M.D., Madison

PREPARED AND SUPPORTED BY THE SECTION ON OPHTHALMOLOGY OF THE STATE MEDICAL SOCIETY OF WISCONSIN

DR. MC CORMICK HEADS STATE O–O

Michael R. McCormick, MD of Waukesha was elected president of the Wisconsin Society of Ophthalmology and Otolaryngology October 9 at Lake Delton. Doctor McCormick's father, George L. McCormick, MD, was secretary-treasurer of this organization for 33 years. John A. Ottum, MD of Green Bay was elected vice-president and James C. Allen, MD of Madison was elected secretary-treasurer.

New members elected into the Society at this meeting were: MDs George H. Bresnick, Madison; Thomas D. France, Madison; Frank L. Myers, Madison; Thomas R. Sawyer, Milwaukee; and Richard O. Schultz, Milwaukee.

WISCONSIN–UPPER MICHIGAN O–O MEETING

The Wisconsin-Upper Michigan Society of Ophthalmology and Otolaryngology met October 9–10 at Lake Delton. Dr. Karl Ossoinig of the University of Vienna addressed the physicians on the subject of the use and future of ultra-sound in ophthalmology. There are two basic types of instruments: an "A scan" instrument and a "B scan" instrument. The A scan localizes in the lesion in the eye or orbit like x-ray but better than x-ray, Dr. Ossoinig explained. The A scan cannot, however, diagnose the type of lesion, he said. The B scan instrument is superior in that it can diagnose the type of lesion such as a hemangioma of the orbit.

After the evening banquet attended by 45 physicians, wives, and residents, Doctor Ossoinig discussed socialized medicine in Austria. There are a number of large insurance companies to which everyone is required to belong, he stated. The insurance companies are paid for by the employe and employer. The insurance companies then pay the doctor.

New members elected to the Society this year are: MDs Thomas R. Sawyer, Milwaukee; and George H. Bresnick, Frank L. Myers, Thomas D. France, and Edwin L. Downing, Madison.

NEW OPHTHALMOLOGIST IN OSHKOSH

Edwin L. Downing, MD recently opened an office for the practice of ophthalmology in Oshkosh. Doctor Downing attended Wheaton College and received his BS degree in 1960. He attended Thomas Jefferson University Medical School, Philadelphia, graduating in 1964.

He had a rotating internship with two months in ophthalmology at Tripler Army Medical Center from 1964 to 1965. In 1966 he was with the U. S. Army in Vietnam. From 1967 to 1968 he was chief of hospital clinics at Kirk Army Hospital, Aberdeen Proving Grounds, Maryland. His ophthalmology residency was spent at the Veterans Administration Hospital, Hines, Ill., from 1968 to 1971.

NEW OPHTHALMOLOGIST AT UW

Thomas France, MD has joined the full-time staff of the Department of Ophthalmology at the University of Wisconsin Medical Center. Doctor France's main area of interest is pediatric ophthalmology.

A native of Marion, Ohio, Doctor France resided in Wausau from 1945 to 1959, graduating from high school in 1955.

Doctor France received his undergraduate education at Northwestern University from 1955 to 1958. He attended Northwestern University Medical School and graduated in 1962. His internship was served at Chicago Wesley Memorial Hospital. He was General Medical Officer in the U. S. Navy at the U. S. Naval Station, Treasure Island, San Francisco, Calif., from 1963 to 1969.

Doctor France was resident in ophthalmology at the University of California San Francisco Medical Center from 1966 to 1969. He served a fellowship in pediatric ophthalmology at Children's Hospital, Washington, D. C. in 1969 and 1970. He spent one year as Honorary Senior Registrar in pediatric ophthalmology at The Hospital for Sick Children, Great Ormand Street, London, England, in 1970 and 1971.

He is married to Nancy K. France, MD who also has recently joined the staff at the University of Wisconsin Medical Center in the Department of Anesthesia.

SHEBOYGAN HAS NEW OPHTHALMOLOGIST

Robert D. Holmstrom, MD recently became associated with Robert Pointer, MD in Sheboygan for the practice of ophthalmology. Doctor Holmstrom graduated in 1962 from Emory University Medical School, Atlanta, Ga., and served a one-year internship at Presbyterian St. Luke's Hospital, Chicago. He joined the U. S. Navy as a flight surgeon and from 1966 to 1969 spent three years in residency in ophthalmology at the naval hospital, San Diego, Calif. □

WISCONSIN MEDICAL JOURNAL
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Medical GREEN SHEET

NEWS OF SOCIO-ECONOMIC MEDICINE

Council Approves Incorporation of Health Care Review

The go-ahead to develop a separately incorporated organization to provide across-the-board utilization and peer review was given by the State Medical Society's Council at its November 18 meeting in Madison.

It is contemplated that the new organization, Health Care Review, Inc., will be incorporated in December and become operational early in 1972. Although the new corporation has received its impetus through efforts of the State Medical Society, it is not a part of the Society structure.

A broad-based, multi-discipline corporation was the mechanism selected by the Council to implement the activity recommended both in its report to the House of Delegates at the May 1971 meeting and also included in the remarks of George A. Behnke, MD, Kaukauna, upon assuming the office of Society president.

Although much has been and continues to be done by the profession in assuring continued high quality of medical care and optimum use of health care facilities and personnel, there was a recognized need for giving greater public visibility to these activities and also to involve disciplines other than medicine. To these ends the Council recommended that the initial incorporators and the ultimate board of directors include representatives of voluntary health organizations other than the State Medical Society; and that once formed, there be appropriate notification of the new corporate body as well as the availability of its services to all legitimate interests.

Established as a Wisconsin nonstock corporation, the purposes of Health Care Review, Inc. will include:

- Developing, promoting, coordinating, and operating health care review which will incorporate the principle of *peer* review for objective evaluation of health care and utilization of services encompassing total health needs of patients;
- To make reviewing and consulting services available to the insurance industry, governmental agencies, interested persons, organizations, and other health care financing institutions;
- To disseminate information to its associated organizations, their members, and the general public the basic objectives and their significant relation to public health.

Since it is contemplated that the governing body will include public (consumer) representation, the board of directors will not undertake actual peer review but rather will make certain that it is done—and done according to general guidelines promulgated by the board.

The various elements of the health care team are being afforded the opportunity to provide peer review capability to Health Care Review, Inc. (HCR) through their respective statewide professional organizations. However, if any group does not offer this service to HCR through its facilities, the board of directors retains the power to make alternative arrangements so as to provide effective utilization and peer review service on a statewide basis and in the public interest.

Phase Two Guidelines Issued

Phase Two guidelines issued by the Price Commission state that charges of professionals and the service industries must remain frozen at Phase One levels unless increased charges are justified by increased costs since November 13. In such instances physicians or other professionals may raise their fees without prior approval of the Office of Economic Preparedness.

Phase Two guidelines rely heavily on voluntary compliance, *but fee and wage increases of any physician are subject to review.* A physician may increase his earnings by increasing his productivity—seeing more patients or performing more services. Wage guidelines for personnel employed by physicians are the same as those for other employers.

Questions concerning Phase Two guidelines, which became effective November 14, should be referred to local Internal Revenue Service offices.

The wage–price regulations were published in the November 13 *Federal Register.* Copies of the *Register* may be obtained for 20¢ from Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402.

Professional Liability Program Still Under Study

A progress report on the feasibility of a Society sponsored professional liability program was presented to the Council by the Committee on Economic Medicine when the Council met November 18 in Madison.

The report was prepared at the request of the Council which had directed that the Committee implement Resolution Q as adopted by the House of Delegates at its May 1971 meeting.

Resolution Q instructed the Council and staff to undertake negotiations with insurance carriers so as to make professional liability protection more available to the membership.

The Council accepted the Committee report and its recommendations that (1) the Committee continue to pursue its endeavors toward ultimate development of a professional liability insurance program under Society sponsorship, (2) the Committee be authorized and empowered to proceed to the point of developing a suggested program of activity subject to Council approval prior to implementation, and (3) a summary of the report be prepared by the Committee and distributed as a progress report to the component county societies in accordance with Resolution Q.

The Committee's report outlined efforts to implement Resolution Q with the initiation of two projects.

One was a survey of the membership to ascertain among other things: (a) the identity of the carriers providing liability protection; (b) the limits of liability carried; (c) the nature and number of problems experienced by the membership during the past five years; (d) the extent to which members had had claims or suits during their professional careers; and (e) the extent to which the members wished the State Medical Society to become involved in the sponsorship of a professional liability insurance program.

The second project was to interview representatives of those insurance companies who had indicated an interest in providing professional liability insurance to members of the Society under some form of Society sponsorship.

Survey

Questionnaires were mailed to the membership involving 4,368 physicians. There were 1,926 responses tabulated and within this number there were indications of 337 suits or claims.

Of the 337 incidences, 157 had been closed for an aggregate amount of $854,419.50. The amount of payment reported on closed claims ranged from a low of $1 to a high of $50,000.

During the past five years 68 physicians indicated that their coverage had been cancelled.

In preferences for SMS involvement, the responses were about even for a program sponsored by the State Medical Society and one sponsored by AMA and cosponsored by SMS. There were 774 responses favoring SMS sponsorship, with 166 opposing and 986 unanswered. For sponsorship by AMA and co-sponsored by SMS there were 768 favoring, 207 opposing, and 951 not answering. Only 371 favored the status quo, 282 answered in the negative, and the remaining 1,273 did not answer.

Observations

In conferences with eight insurance company representatives, the Committee learned that there was little promise for immediate relief in premiums but that the companies were seeking to stem the rising spiral of costs and stabilize losses so that ultimately there could be prospects of premium reductions. But representatives emphasized the industry's interest in long-term arrangements and its concern about the recent trends in liability insurance underwriting. Any approach which stresses consideration of premium alone might well be of short-term benefit, and conceivably could result in an even more restricted availability of coverage, they warned.

The Committee concluded that sponsorship of any meaningful program is a serious matter and one which involves deep commitment of the Medical Society in a number of areas. But it hastened to add that recognition of multiple and varied problems is not an excuse to abandon the objectives, but rather to suggest a status report, request additional time for continued studies and negotiations so as to be able to make more definite recommendations at a later date.

Some rather key considerations need to be resolved before a decision is reached regarding the sponsorship of a program of this nature, the Committee concluded.

Green Bay Free Clinic Staff Has 13 Volunteer MDs

Patients ranging in age from six months to 76 years have been treated at the Green Bay Free Clinic since it opened at the end of July.

Now, after donations saved it from closing its doors when the rent came due, the clinic is looking for a permanent home and a grant to keep it in operation.

The all-volunteer staff is composed of 13 physicians, 19 registered nurses, 12 medical technicians, three professional counselors, ten paraprofessional counselors and four other workers.

MDs John Randall and Jeremy Green are the clinic's two medical directors. The clinic is governed by a seven-man board which includes the two directors, two administrators, a nurse, a medical technologist and the head of the counseling staff.

Some of the clinic's equipment and most of its laboratory and x-ray work have been supplied by local hospitals. All of its drugs are donated.

The clinic, located in the heart of Green Bay near the university, is open three mornings a week and the staff hopes this can be expanded as more physicians are involved and a larger facility is found. Its services are those of a standard outpatient clinic and include treating common medical problems, giving physicals, and doing counseling.

MEDICAL GREEN SHEET is published monthly as a special feature in the *Wisconsin Medical Journal*, official publication of the State Medical Society of Wisconsin, to provide current news of socio-economic interest to physicians and others. Green Sheet copy deadline: first of month. SMS Hot Line copy deadline: tenth of month. Copyright 1971 by State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

MANAGING EDITOR: Earl R. Thoyer, Secretary, State Medical Society of Wisconsin.

AMA Adopts Wisconsin Plan to Obtain Members' Views

A Wisconsin delegation resolution calling for open hearings on the future organization of the American Medical Association was adopted by the AMA's House of Delegates meeting in New Orleans.

At the concluding session of the AMA's Clinical Convention Nov. 28–Dec. 1, the House accepted the Wisconsin resolution without discussion. It calls for hearings at the next two AMA conventions to obtain members' views with final recommendations due at the 1973 Annual Convention in New York City.

The AMA Council on Long-Range Planning and Development will hold the hearings at the 1972 Annual Convention next June in San Francisco and at the Clinical Session in Cincinnati in November and give progress reports at these meetings.

In proposing the resolution, R. E. Galasinski, MD of Milwaukee told the House that the Wisconsin delegation came to the convention with "a virtual mandate from our Council and our membership to seek a Constitutional Convention or its equivalent and some type of action to effect certain organizational and program changes in the AMA."

The resolution was adopted by the House in response to a call by AMA President Wesley W. Hall, MD, for a Constitutional Convention to restructure the organization format of the Association and streamline its governing processes. Dr. Hall renewed his plea made originally at his inauguration in Atlantic City last June.

The Wisconsin resolution reversed a reference committee proposal which would merely have referred Dr. Hall's ideas to a committee without a requirement for action.

Both the AMA's Council on Constitution and Bylaws and its Council on Long-Range Planning and Development had recommended to the House that a Constitutional Convention not be held. Both councils agreed that the mechanisms for bringing about constructive changes in the AMA are spelled out in the Constitution and Bylaws, and are adequate and workable.

In presenting the Wisconsin resolution, Dr. Galasinski pointed out that the AMA House of Delegates created the Council on Long-Range Planning and Development "charged specifically with the goals that many members seek for a changing Association in a changing world."

He said "pressure for a Constitutional Convention will continue until the membership sees specific productive results from the Council on Long-Range Planning and Development."

* * *

Other House action taken on business presented by the Wisconsin delegation included adoption of a 30-day rule for submission of resolutions before House of Delegates sessions.

The new rule, which is to be put in effect through changes in the AMA Bylaws, requires that non-emergency resolutions to be brought before the House must be received at AMA headquarters at least 30 days before the session begins. Virtually all of the testimony heard on the resolution was favorable. The reference committee on the resolution noted that "members of this House are entitled to a reasonable opportunity to review the matters they will be asked to vote on."

The House also passed a memorial resolution honoring William D. Stovall, MD, long active in the State Medical Society of Wisconsin and the AMA. Dr. Stovall, who died November 18 at age 84, was cited for his 16 years of service in the AMA House of Delegates and his work on the Association's Council on Constitution and Bylaws.

AMA Now Requires Resident Members to Pay $20 Dues

As a result of action taken by the AMA House of Delegates at the Annual Clinical Session in New Orleans earlier this month, Resident members of the AMA will be assessed $20 for dues for 1972. Until now Residents paid only county (where applicable) and state dues, with AMA dues being waived.

This month, Wisconsin Residents will be receiving a 1972 dues statement, including the AMA's $20 as well as the county (where applicable) and $3 state dues. Payment of dues is to be made to the county medical society.

In Wisconsin, Residents who wish to be members of the medical societies must belong to the county and state medical societies as well as the AMA. The AMA's "direct" membership classification for Residents does not apply in Wisconsin since membership is available through the county and state societies. The State Medical Society of Wisconsin does not provide for membership by Interns; therefore, Wisconsin Interns may apply directly to the AMA for membership.

Medical Museum Season Sets Receipts Record

The Museum of Medical Progress in Prairie du Chien closed its eleventh season October 31 with record attendance for the last month and record receipts for the season.

This year's feature exhibit was the first educational ecology exhibit in the nation, "Eco Expo." In addition, during the last week of the season the Museum had the first public showing of health careers posters by high school students who took part in the 1971 Wisconsin Health Council contest.

Museum visitors this season included physicians from many states and several foreign countries. In addition there were a wide variety of groups from schools, clubs, youth and senior citizen groups, and other visitors from almost every state and foreign country as diverse as Iceland, India, and Uganda.

Society Gives Grant to "Dear Doctor" Program

Can heroin be smoked? Is opium made of refined hashish? Does marijuana cause impotency? Is cocaine addicting?

Straight answers to questions like these and others on drugs make up a call-in radio program, "Dear Doctor," to be partially supported with a grant from the State Medical Society of Wisconsin and broadcast over the nine FM stations of the state radio network.

The Wednesday evening program, which will start January 5 on the state FM network, has been carried for the past two years on a Milwaukee area FM station. With State Medical Society support, listeners across the state can benefit from the questions answered by Alan E. Reed, Jr., MD, Director of Milwaukee's Underground Switchboard Free Medical Clinic and Counseling Center.

The Society's grant will help pay for a free telephone line over which anyone in Wisconsin can call Milwaukee during the live show and talk to Dr. Reed.

Dr. Reed describes his role on the "Dear Doctor" program as "trying to provide a source of reliable information on drugs rather than a moral viewpoint . . . I do not see my position on this program as being one of deciding what other people should do. But rather of providing individuals with information so that they're better able to make their own decisions concerning their own lives."

The "Dear Doctor" program has established a reputation for honesty and credibility among young people in southeastern Wisconsin.

Bob Reitman, program director of WZMF from which the show is broadcast, has hosted the program since its beginning.

He says, "It seemed that people were having troubles getting straight answers about drugs because of a lack of proper information on the part of people who were answering questions. Old myths about drugs were being perpetuated at the same time as many new and, for the most part, impure drugs were showing up with increasing frequency on the streets.

"We just thought someone should be offering proper information based on scientific fact," he says.

In the future it is planned that experts in fields other than drugs will be available for listeners' questions.

Dr. Reed was once associated with the Haight–Ashbury Medical Clinic in San Francisco. He is now a third-year fellow in psychiatry at the Medical College of Wisconsin and the Milwaukee Psychiatric Hospital. He is chairman of the Milwaukee County Medical Society's Committee on Alcoholism and Drug Abuse and a member of the Task Force on Drug Abuse of the Milwaukee Mental Health Planning Committee.

President-elect Purtell Talks

The State Medical Society's president-elect, Robert F. Purtell, MD of Milwaukee, was the featured speaker at the November 17 meeting of the Green County Medical Society in Monroe.

Dr. Purtell devoted his remarks to problems in state legislation as it relates to the medical profession and the overall health of Wisconsin residents.

Attention! Physicians Over 70 Years of Age

The Society reminds physicians who are over 70 years of age that they are **not** required to pay AMA dues as long as they are regular members of their state medical society.

Upon request, this may become effective the year after the physician reaches the age of 70 and cannot be made retroactive.

The physician must make the request to his county or state medical society and he must continue his membership in the state society to be eligible.

This dues-exempt classification does not include receiving AMA publications, but they can be obtained by direct subscription through the AMA.

Other AMA dues exempt classifications may be requested through the county or state medical society for the following reasons: financial hardship, illness, retired from active practice, temporary service in the Armed Forces, as well as the over-70-years-of-age category.

While the State Medical Society of Wisconsin has an associate membership classification which exempts a retired physician member from payment of dues regardless of age, it does require payment of state dues for those over 70 years of age who are in active practice.

The State Medical Society urges all physicians who are retired or will be retiring to advise their county or state society of their present or future status so that a change in classification can be arranged.

Dr. LaBissoniere Elected to Council

Paul G. LaBissoniere, MD, a Wauwatosa internist, was elected to the State Medical Society's Council at its October 23 meeting in Madison.

He fills the unexpired term of James M. Sullivan, MD of Milwaukee who resigned for health reasons. The three-year term runs until May 1973. He joins five other councilors from the 12th district which is Milwaukee County.

Dr. LaBissoniere

Dr. LaBissoniere has practiced in Milwaukee and Wauwatosa since 1948, having graduated from the Marquette University School of Medicine in 1943. His internship and residency were taken at Milwaukee County General Hospital.

During his residency years, he also served in the United States Army Medical Corps. He was named director of the Marquette University Student Health Clinic in 1948. He has been chief of staff of St. Joseph's Hospital since 1967 and a member of the medical staffs of Milwaukee County General, St. Michael, and West Allis Memorial hospitals.

An active participant in the affairs of The Medical Society of Milwaukee County, he was named chairman of the county society's hospital relations committee last year. He is president of the Milwaukee Academy of Medicine this year.

Council Considers Perinatal Health Care Authority Plan

A proposal to create an independent perinatal health care authority and seven regional perinatal care councils through legislative action was presented to the State Medical Society's Council November 18. The Council agreed to give it further consideration.

MDs T. A. Leonard and J. M. Schneider of Madison spoke to the Council on behalf of the Wisconsin Association for Perinatal Care which was established during the past year by interested physicians, nurses, hospital administrators, and others from public health and comprehensive health planning.

The Society's liaison with this organization is maintained by the Division on Maternal and Child Welfare through its Maternal Mortality Study Committee, and specifically through its chairman, Dr. Leonard.

The Association provided the major impetus for the introduction of Senate Bill 597 calling for the creation of such an authority and regional councils for the purpose of improving the quality of health care for expectant mothers and newborn infants primarily through hospital-based programs.

The Council had considered this bill at previous meetings during which it took the position that this activity should not be the subject of legislation, but that educational programs designed to improve the quality of health care for expectant mothers and newborn infants should be initiated voluntarily.

Doctors Leonard and Schneider appeared before the Council at this time to ask for reconsideration of the Council's position.

Senate Bill 597 has been recommended for passage by the Senate Committee on Health and Social Services (4–0) and referred to the Joint Finance Committee where it remains.

An analysis of the bill by the Legislative Reference Bureau follows:

"This bill creates the Wisconsin perinatal health care authority and regional councils. The purpose of these entities is to improve the quality of health care, especially hospital care, for expectant mothers and newborn infants. Hospitals which supply such care must meet criteria established by the authority.

"Seven geographical regions are established for the councils, but the authority may change them on petition of a participating hospital. The membership of the authority consists of regional representatives and other specified persons to be appointed by the state health officer and by certain health-related organizations.

"A 7-year period of operation is suggested for the authority, and a committee to be appointed by the state health officer is to recommend subsequent disposition."

In the appended fiscal note the bill establishes a fee of $10 for each obstetrical patient and appropriates $250,000 in GPR (General Purpose Revenue) funds to finance the program.

The Council's concern with the proposed legislation is based almost entirely upon the implications of assessing $10 per obstetrical patient in a hospital to help finance the program. And there also is the question as to the extent of physician representation.

UW President John Weaver Addresses Society Council

University of Wisconsin President John C. Weaver addressed the State Medical Society's Council November 18 to express his views on the effect of merger by the two state university systems as well as the development of health care in Wisconsin.

He stated his belief that the merger would enhance the delivery of medical education and health care in the state. He also emphasized his great concern for the rapid expansion of physician output through the two Wisconsin medical schools—University of Wisconsin in Madison and Medical College of Wisconsin in Milwaukee.

He said it makes more sense to expand the two existing schools rather than create a third school and thus dilute resources.

Task Force Work Group Considers Cost of Care

Problems in paying for health care were explored at a recent meeting of the finance work group of Governor Lucey's Health Planning and Policy Task Force. Specialists in several areas were invited to give their viewpoints and suggestions on health care financing.

The discussions were rambling and at the end of the meeting several members of the group asked that in the future a different approach be taken to get the focus on the more important matters of concern.

Wisconsin Insurance Commissioner Stanley DuRose pointed out that the committee would have to examine the relationship of existing payment mechanisms to national health insurance. He said he felt a number one area of inquiry should be the provider, because of the lack of "price competition" among doctors and hospitals.

Ben Lawton, MD of Marshfield, said it appeared everyone was ready to control the provider and asked "who will do something about the carriers?" He also suggested that some attention be given to the so-called hospital-based specialties and their charges in relation to total provider charges.

Invitces to the work group meeting included John R. Sumnicht, State Group Insurance Board; Judith Ladinsky, UW assistant professor of preventive medicine; Insurance Commissioner DuRose and Deputy VanCleave; Richard Heins, UW School of Commerce; David Gustafson, UW associate professor of preventive medicine; Patrick Clifford, Sentry Insurance; Roy Menzel, Wisconsin Dental Service Corporation; Robert Lampman, UW professor of economics; David Neugent, Blue Cross; and Roger Graham, WPS Blue Shield research and planning director.

Named to Nursing Committee

Howard V. Sandin, MD of Ashland recently was named to a 20-member advisory committee established by the State Board of Nursing to evaluate and implement action necessary for statewide planning for nursing education in Wisconsin.

Pharmacist Group Sets Record Straight on Generic Prescribing, Drug Substitution

The Wisconsin Pharmaceutical Association has notified the State Medical Society that it does not support mandatory generic prescribing, but that it does support the development of a statewide drug formulary and a method of drug substitution.

The association said that following public hearings on Assembly Bill 206 (which requires the prescription and dispensing of all drugs by their generic names), it "held discussions with certain of the primary authors of the bill and was asked to submit an alternate proposal." The association drafted such a proposal and has submitted it to an Assemblyman for possible introduction in January. The pharmaceutical association proposal would establish a drug quality review board of nine members, including one member of the State Medical Society. This board would prepare a formulary consisting of a list of drug products commonly prescribed in Wisconsin by their brand names. Drug product equivalents would be placed together in the list and ranked according to their average wholesale cost. This formulary would be made available to all practitioners licensed to prescribe drugs and to pharmacists licensed to dispense.

If the prescribing practitioner wrote on the prescription order "no alternate" or the abbreviation "NA," no drug product equivalent could be dispensed under that prescription. However, if the practitioner did not indicate "no alternate," the dispensing pharmacist could dispense any drug product equivalent from the formulary provided it had an average wholesale cost no greater than the drug product named in the prescription order.

Dispensing pharmacists and physicians would be required to label drugs either by their brand or generic name, or a national drug code number. The pharmacy association has indicated that it opposed both the original Assembly Bill 206 and Substitute Amendment 1 to the same bill.

Experimental HMO-type Programs Under Study by Society's CMCP

The Commission on Medical Care Plans reported to the Council November 18 that it has been meeting with the Dane County Medical Society in efforts to effect an experimental "health maintenance program" similar to those now under discussion within several county medical societies.

Out of these meetings has come suggested changes to adapt the program to the specific characteristics of medical practice in the area.

In reporting the details, the Commission chairman, E. M. Dessloch, MD of Prairie du Chien, stated that the plan contemplates a combination of fee for service and fixed monthly payment to physicians, anticipating that the experimental plan will provide some reliable data on which to base a comparison with current health insurance programs available in the area. For example, he said, it should provide more firm information on the question of whether the availability of a broad range of "out of hospital" benefits does result in a measurable reduction in insurance costs for hospital services.

Other matters reported by the Commission included the following:

- A contract benefit for sterilization procedures is still under consideration by the Commission.
- The Wisconsin Physicians Service (WPS Blue Shield) September financial statement showed continued favorable results during the year. For the nine-month period ending with September total income was $34,191,520 while claims and operating expenses were $33,186,-336, leaving net income available for reserves of $1,005,184.
- The Commission has approved the renewal of a two-year contract with the Office for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) —an extension beyond the previous one-year commitment.
- The Governor has signed into law a bill to be effective for the year beginning January 1972, which results in an income tax on the Blue plans in Wisconsin. While determination of net income remains to be worked out, the percentage will vary consistent with current corporate tax levels from approximately 2 to 8 percent on net income. The Commission believes this is in effect an additional sales tax, since it must be passed along to WPS Blue Shield subscribers in the form of higher rates. However, from the standpoint of both subscribers and the Blues it is a more favorable approach than a premium tax.

Five MDs Receive Awards for Blue Shield Service

Plaques of recognition have been awarded to six members of the State Medical Society's Commission on Medical Care Plans (CMCP).

MDs Guy W. Carlson, Appleton; Albert W. Hilker, Eau Claire; Howard Mauthe, Fond du Lac; L. O. Simenstad, Osceola; and Frederick H. Wolf, La Crosse; and Mr. Sylvester H. Dretzka, Milwaukee, were cited on the plaque for "devoted services and outstanding contributions toward the development, promotion, and preservation of quality prepaid health insurance in Wisconsin." The tenure of the six on the Commission totals 82 years.

The CMCP has 24 members including 20 physicians and 4 nonmedics from all parts of the state. It directs all of the Society's health insurance activities. The Society's Blue Shield Plan, Wisconsin Physicians Service (WPS), is celebrating its 25th anniversary this year. The Commission was organized in 1950 to succeed a group of committees associated with the insurance program.

Dr. Carlson, whose service on the Commission was the longest of the five, was among the CMCP's original members appointed in 1951. Before that time he had been a member of the Wisconsin Plan Committee, one of the previously existing insurance committees. E. M. Dessloch, MD, Prairie du Chien, has been chairman of the Commission since its inception. Commission members are appointed by the Chairman of the State Medical Society Council and serve for three-year terms.

Marshfield Plan Praised by HEW's Richardson

Health, Education and Welfare Secretary Elliot L. Richardson visited the Marshfield Clinic October 17 and praised its work in establishing a prepaid health care program with St. Joseph's Hospital as "pioneering" and "an example that the rest of the U.S. would do well to emulate."

Richardson spoke at a dinner in the Marshfield Clinic which was attended by Secretary of Defense Melvin Laird and Wisconsin Congressmen John Byrnes and Clement J. Zablocki.

He told sponsors of the seven-month-old Greater Marshfield Community Health Plan that his door is open for talks about possible partial funding of the program as a test for the country.

David Jay, administrator of St. Joseph's Hospital, and Ben Lawton, MD, president of the Clinic, told Richardson that the two medical facilities have linked to form a regional health care program that parallels but predates President Nixon's call for health maintenance organizations throughout the country.

The plan allows families regardless of size and income to receive a wide range of medical care at the two centers for about $600 a year. Benefits include 365 days of hospitalization, 70 days of psychiatric care, and a full range of medical treatment, including outpatient care, at no cost other than the monthly premiums.

TALKING OVER THE MARSHFIELD community health care plan are left to right: Ben R. Lawton, MD, Marshfield; HEW Secretary Elliot L. Richardson and Defense Secretary Melvin R. Laird, Washington, D.C.; and David Jay, Marshfield.

Because the program began on March 1, it was already in existence when President Nixon called for his program and therefore was not designated a pilot project for financing.

Federal financial aid is needed to extend membership to families with incomes from $3,700 to $7,000, Dr. Lawton said. Families in this income range aren't poor enough for welfare and aren't rich enough to afford $600 a year for prepaid health care. One of the plan's goals is to reach this group.

Currently, 9,000 persons in the area are enrolled, out of an estimated population of 35,000 to 40,000. A spokesman for the program put the cost of aid for poorer members at between $8 million and $10 million for the pilot period.

Laird, whose former Congressional district included the clinic and hospital, told Richardson that the Marshfield experiment could be "a pilot project, a bellweather, that can give the kind of statistics needed so that a proper judgment can be made" of the proposals being pushed by Nixon and HEW.

State H&SS Board Asks Changes in Certificate of Need Bill

State certificate of need legislation was supported by the state Health and Social Services Board at its October 27 meeting. However, the Board expressed concerns and reservations about the legislation as presently proposed.

Its support of Assembly Substitute Amendment 1 to A-1104 is contingent upon deletion of all references to unlicensed facilities and professional services. It also suggested that "health care institutions" be redefined in the bill to mean only those subject to licensure or approval by the Department of Health and Social Services.

The position taken by the Board was in line with that enunciated by the State Medical Society's Council and House of Delegates a few days earlier. At the Board meeting H. J. Kief, MD, Fond du Lac, Board vice-chairman, explained the State Medical Society's position on certificate of need.

State Medical Society Secretary Earl Thayer read the Board the resolution on certificate of need legislation adopted at the October 23 special session of the Society's House of Delegates.

Mr. Thayer also discussed with Board members the changes in staffing in certain general hospitals that would be necessary under "certificate of need" to give all physicians and patients access to facilities and services which are available only in a few locations around the state. The Board noted that this was the first time it had been made aware of the necessity for arrangements to effect "open staff" operations under certificate of need.

William H. Studley, MD, Shorewood, asked to be recorded as voting no on the Board's motion authorizing the secretary of the Department of Health and Social Services to appear in support of passage of a modified version of Assembly Substitute Amendment 1 to A-1104.

Organ Donors to Have IDs

Organ donors may now stick an identifying decal on their drivers licenses to identify themselves in case of accident. In November Gov. Patrick Lucey signed a bill into law which specifies that the decal must be supplied by a nationally recognized organization which enlists such donors. The National Kidney Foundation supported the bill.

Dr. Weygandt, the 'Safety Doctor'

"What makes 'safety doctor' run so fast?" A recent front page article in the Plymouth *Review* tries to answer that question with an in-depth look at one of Sheboygan County's leading residents, James Weygandt, MD, of Sheboygan Falls.

The article pictures a physician who spent much of his first ten years as an MD looking at and treating the results of automobile accidents. His second MD decade has been spent trying to make others see the need for steps to prevent those injuries from occurring.

Dr. Weygandt

His initial inspiration to become actively involved in highway safety causes was a New York doctor who had successfully worked for passage of an implied consent law to test blood alcohol of drinking drivers. Dr. Weygandt was impressed that the New York MD had sacrificed part of a successful practice to do it.

The *Review* article quotes him as saying that "The idea mushroomed for me."

He became a member of the State Medical Society's Division on Safe Transportation in 1961 and has been chairman of the Commission on Safe Transportation since 1965.

Among his major safety triumphs have been the passage of a state implied consent law and the establishment of the Medical Society's Commission on Safe Transportation as the medical advisory committee to the State Department of Transportation.

His own automobile has logged thousands of miles on state roads in the process. Sometimes Dr. Weygandt purposely takes the long way to a Madison meeting from Sheboygan Falls. He likes to avoid the risky "cowpath" (highway 23) to Fond du Lac and southwest.

Even so, the long trip is filled with accident potential. Three years ago at a State Medical Society Work Week of Health Dr. Weygandt listed this potential as the "Five I's": immaturity, inattention, impatience, intoxication, and incapacity.

But at least today's cars now have a few more protective features—padded dash, new glass, lap and shoulder harnesses.

Why?

Because of "prodding" by Dr. Weygandt and others who believe such changes would not come about spontaneously.

The *Review* quotes one of the doctor's favorite phrases, "Good ideas don't command automatic action."

Over the years his projects have included promoting a number of good ideas in the name of safety. More recently, these have gone beyond the medical, but have always stayed as far as possible from the political. He doesn't think of himself as a politician ("perhaps it doesn't fit my character").

His concern is getting through the political process to reach ways of cutting down on the number of people left bloody along roadways.

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New Society Appointments

SMS Council Chairman, E. J. Nordby, MD of Madison, has announced the appointment of two physicians to committees of the Society.

Elmer E. Johnson, MD of Madison was appointed to the Commission on Safe Transportation to succeed A. A. Herrmann, MD of Racine who resigned.

Cameron Gundersen, MD of La Crosse was appointed to the Medical Student Liaison Committee to fill a vacancy created by the death of C. G. Reznichek, MD of Madison.

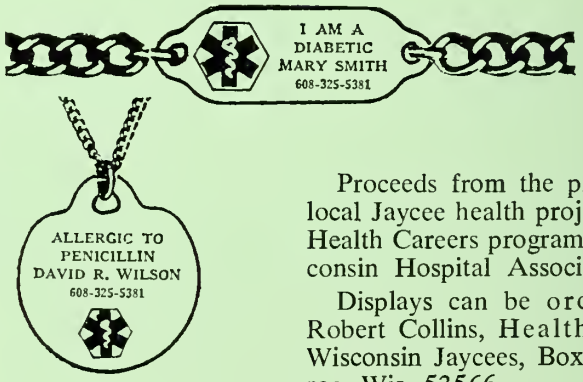
Jaycees Selling Medical ID Tags

Contact lenses, allergies, and diabetes are some hidden medical problems that could needlessly endanger lives if the incapacitated emergency patient could not alert others.

Tags to identify such hidden problems are being sold in a new Wisconsin Jaycees project. The State Medical Society of Wisconsin and the Wisconsin Hospital Association are cooperating with the Jaycees in promoting their Emergency Medical Identification Project.

The Jaycees have made the tags available at a low cost through displays in physicians' offices, pharmacies, hospitals, and similar places.

Tags on neck chains and bracelets bear the universal emergency medical identification symbol, developed by the AMA, and four lines of information. A tag listing name, telephone number or blood type, and one of the 14 most common medical conditions is $2. Special tags will be engraved to order for $3.



Proceeds from the project go to local Jaycee health projects and the Health Careers program of the Wisconsin Hospital Association.

Displays can be ordered from Robert Collins, Health Chairman, Wisconsin Jaycees, Box 498, Monroe, Wis. 53566.

NEWS HIGHLIGHTS

Dr. Otis Epley Marks 91 Years

A physician who has delivered more babies than there are people living in his town, Dr. Otis Hoyt Epley* celebrated his 91st birthday November 4.

Born and raised in New Richmond (1970 population 3,686), Dr. Epley left the town only during the years he was getting his education. Three years after his 1904 graduation from Rush Medical College in Chicago he returned to New Richmond to practice and is there today.

Dr. Epley was the third generation of his family to practice medicine in St. Croix County. In 1854 his grandfather, Dr. Otis Hoyt, settled in Hudson following his service in the Mexican War as a medical officer. Dr. Hoyt was a surgeon in the Civil War as well as a founder of the State Historical Society of Wisconsin.

Dr. Hoyt's daughter married Dr. Frank W. Epley, Dr. O. H. Epley's father. The senior Dr. Epley was State Medical Society president, 1895–1896.

There have been Epleys in New Richmond for almost a century. Dr. Frank W. Epley graduated from Rush Medical College in 1877 and practiced in New Richmond until his son took over the practice at the same location in 1907.

Dr. O. H. Epley, a life member of the State Medical Society, served as president and secretary of St. Croix County Medical Society. For several years was a delegate or alternate to the State Medical Society. He also served on the State Medical Society Committee then known as Mental Hygiene and Institutional Care. This reflected his work as a visiting physician at the St. Croix County Hospital. In New Richmond Dr. Epley was chief of staff of Holy Family Hospital and also was the local surgeon for the Chicago and North Western railroad.

In an age when many are long out of the mainstream, Doctor Otis Hoyt Epley is still a familiar and well-loved member of his community.

Dr. Gordon Davenport, Madison Heads Plastic Surgeons

The recently announced officers of the Wisconsin Society of Plastic Surgery are: Gordon Davenport, MD,* Madison, president; Paul Natvig, MD,* Milwaukee, vice-president; and John E. Hamacher, MD,* Madison, secretary-treasurer.

Dr. Davenport also will serve as the chairman of the State Medical Society's newly created Section on Plastic Surgery and will be the Section's delegate to the SMS House of Delegates. Dr. Natvig is the alternate delegate.

Coronary Artery Disease Seminar Held, Eau Claire

Nearly 100 Wisconsin physicians attended the one-day seminar on "Recent Advances in the Treatment of Coronary Artery Disease" November 5 at Luther Hospital and Hillcrest Country Club, Eau Claire.

Co-sponsoring the seminar were the Eau Claire Heart Association, Wisconsin Heart Association, and Luther Hospital. George Owen, MD,* an internist at the Midelfort Clinic in Eau Claire, was director of the session.

Dr. Owen opened the seminar with a discussion of "General Evaluation of Chest Pain." Seven other physicians spoke during the afternoon session on "Exercise Evaluation of Coronary Artery Disease" and "Coronary Artery Disease—Disappointments Which Persist."

The evening program at the Hillcrest Country Club featured Harold W. Harding, MD, thoracic and cardiovascular surgeon, Fox Valley Surgical Associates, Ltd., Appleton. His topic was "Coronary Artery Surgery."

In addition to Doctors Owen and Harding seminar speakers included L. H. Frase, MD; D. R. Griffith, MD;* J. W. Rogers, MD; J. H. Wishart, MD;* Philip Happe, MD, all internists of the Midelfort Clinic; A. J. Klein, MD,* internist in private practice, Eau Claire; and Emil Schulz, MD, radiologist, Luther Hospital.

PHYSICIAN BRIEFS

Joseph W. Edgett, Jr., MD

. . . La Crosse, recently became a member of the department of internal medicine at the Gundersen Clinic and the Lutheran Hospital in La Crosse. Doctor Edgett graduated from the University of Oregon Medical School, Portland, where he fulfilled his internship. He served with the United States Army from 1960–1971 where he also completed his residency at Fitzsimons General Hospital, Denver, Colo., and at Walter Reed General Hospital, Washington, D.C. Doctor Edgett was the staff cardiologist at Walter Reed; assistant chief of cardiology, Fitzsimons; and chief medical consultant with the Army Medical Command in Vietnam.

Dr. Edgett

Dr. Lawton

Ben R. Lawton, MD*

. . . Marshfield, recently participated in a conference on "Medical Education and Medical Care—A Dynamic Equilibrium?" sponsored by the Fogarty International Center and the Bureau of Health Manpower in Washington, D.C. Doctor Lawton, chairman of the Health Policy and Program Council, spoke on "Non-Academic Careers in Medicine."

Henry C. Rahr, MD*
Donel Sullivan, MD*

. . . Green Bay physicians, recently were named charter diplomates of the American Board of Family Practice.

Physicians who are members of the State Medical Society of Wisconsin are identified with an asterisk following their names.

Edward M. Anderson, MD*

. . . a member of the radiology department at the Gundersen Clinic for the past 13 years, recently retired. A graduate of the University of Minnesota Medical School, he served in World War II as a major in the Army Air Corps. After service he returned to the University of Minnesota for specialized training in diagnostic roentgenology and radiation therapy. He was on the medical staff at St. Cloud Hospital, St. Cloud, Minn., prior to joining the Gundersen Clinic in 1958.

Robert C. Puestow, MD*

. . . Manitowoc, recently was elected president of the medical staff of Holy Family Hospital, Manitowoc. MDs Robert L. Dernlan* and L. W. Holder,* Manitowoc, were elected vice-president and secretary-treasurer, respectively. MDs Harry E. Schaefer and Thomas H. Rees were named members-at-large.

George H. Handy, MD*

. . . Madison, State Health Officer, recently was appointed by Governor Patrick J. Lucey to the Council on Highway Safety.

Thomas C. Meyer, MD*

. . . associate dean of the University of Wisconsin–Madison Medical School, has recently been elected a fellow of the Royal College of Physicians in England. He has been a member of the RCP since 1954.

James L. Weygandt, MD*

. . . Sheboygan Falls, recently participated in the American Association for Automotive Medicine's 15th Annual Conference at Colorado Springs, Colo. He is secretary of the association.

W. T. Russell, MD*

. . . Sun Prairie family physician, speaking to the 20th Century Club pointed to future health care in Sun Prairie as being a major concern to all. He explained his efforts toward establishing a center in Sun Prairie which could provide the basis for training of medical students under the recently established family medicine program at the University of Wisconsin Medical Center, Madison.

Dr. R. R. Baumann, Monroe, Heads Dermatologists

Robert R. Baumann, MD* of Monroe took office as president of the Wisconsin Dermatological Society at its fall meeting October 30 in Milwaukee at the Veteran's Administration Hospital.

Other officers elected are: vice-president, Robert B. Pittelkow, MD,* Milwaukee; and secretary-treasurer, Hubert V. Moss, MD,* Madison.

Officers for the coming year for the State Medical Society's Section on Dermatology are the same as those for the WDS.

Twenty-five members and 14 guests attended the meeting which consisted of 24 case presentations. Following the academic program, the participants were joined by their wives for dinner at the Milwaukee University Club.

La Crosse Area Physicians Discuss Pediatric Anesthesia

A special scientific program on pediatric anesthesia was held in La Crosse November 8. It was sponsored by the Adolf Gundersen Medical Foundation.

Featured speaker was Robert M. Smith, MD, professor and chairman of the Department of Anesthesia, Children's Hospital Medical Center, Boston, Mass.

Other participants in the program were Brian Dawson, MD, consultant in anesthesiology at Mayo Clinic; Betty Bamforth, MD,* professor of anesthesiology, University of Wisconsin Medical Center; also Erik Gundersen, MD,* Department of Pediatric, Thoracic, and Cardiac Surgery; J. Michael Hartigan, MD,* Department of Pediatrics, and David Goodnough, MD,* Department of Anesthesia, Gundersen Clinic, Ltd.

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Dr. J. D. Millenbach, New President, Lincoln Society

Earl Thayer, secretary of the State Medical Society of Wisconsin, Madison, addressed members of the Lincoln County Medical Society at its meeting November 2 in Tomahawk.

He discussed the current legislative proposals, health maintenance organizations, and the current alternative proposals for national health insurance.

Also present were the following guests: Russell F. Lewis, MD*, ninth district councilor, Marshfield; Glenn Waldschmidt, field representative of the State Medical Society, Mosinee; and Vern Sturtz, supervisor of Clerical Systems for the Medicare program administered by WPS Blue Shield, Madison.

Newly elected officers to terms starting January 1, 1972, are: president, J. D. Millenbach, MD,* Merrill; first vice-president, Orlando M. Francisco, MD,* Tomahawk; and secretary-treasurer, T. O. Vechinski, MD,* Merrill.

Neuilo L. Bugarin, MD,* Tomahawk, was named a delegate to the State Medical Society, and Doctor Francisco was named the alternate delegate.

Grafton Medical Clinic Started

Groundbreaking ceremonies for the new Grafton Medical Clinic were held October 30. The Grafton Medical Foundation since mid-1970 has been planning the facility which will accommodate five physicians and is expected to substantially relieve the acute doctor shortage in the Grafton area.

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18 Wisconsin Physicians Become New FACSs

Eighteen Wisconsin physicians were inducted as new fellows of the American College of Surgeons during its annual five-day Clinical Congress October 18–22 in Atlantic City, N.J.

They are: MDs Richard S. Ostenso,* Eau Claire; John M. Mills,* Green Bay; Ubaldo A. Alvarez,* La Crosse; Ronald C. Rudy* and Raul F. Waters,* Madison; Richard R. Whereatt,* Manitowoc; Robert B. Dawes* and Uriel R. Limjoco,* Menomonee Falls; Joseph J. Adamkiewicz, Jr.,* Robert J. Flemma,* Mark C. Kiselow,* and Henry B. Wengelewski,* Milwaukee; Richard F. Hearn,* Oconomowoc; William A. Crawford,* Oshkosh; Sherali Khoja* and Mohammed Rafullah,* Racine; Robert E. Bartos,* Waukesha; and Richard M. Clifford,* West Allis.

Inter-Library Loans Simplified at MCW

The Medical–Dental Library at the Medical College of Wisconsin was recently named a "designated library" by the Regional Medical Library Directors. This means that materials not available in the Midwest Region may be obtained on inter-library loans from the National Library of Medicine directly through MCW rather than through the Midwest Regional Library.

The MCW library is the first in the Midwest Regional Medical Library Area to be so designated.

For information on specific loan requests, contact the Medical–Dental Library, Area Code 414, 272–5450, ext. 240.

Dr. R. C. Brown Elected President, OB–GYNs

Richard C. Brown, MD* of the Midelfort Clinic in Eau Claire was elected president of the Wisconsin Society of Obstetricians and Gynecologists at its October meeting in Lake Geneva.

Herbert W. Sandmire, MD* of Green Bay was elected president-elect and will take office as the president in October 1972.

William J. O'Leary, MD* of La Crosse was reelected secretary-treasurer for a two year term.

H.S. Marijuana Users Tend to Experiment with Other Drugs, UW Study Indicates

Those who use marijuana and those who do not have sharply different opinions and perceptions about drugs in general, according to a recent study of Madison senior high school students by a University of Wisconsin professor.

Jon G. Udell, PhD, a professor in the UW Graduate School of Business, has found that these differences would indicate a greater tendency for marijuana users to experiment with other drugs.

He says, "While the substantially higher frequency of experimentation with drugs such as LSD, opium, and speed among marijuana users does not prove that using pot may lead to the use of more dangerous drugs, it does constitute evidence to that effect."

Dr. Udell drew his conclusions from results of a questionnaire given to 800 students from each of Madison's five high schools. The students were not asked to identify themselves and were promised that their answers would not be seen by school administrators.

Dr. Udell found that 67% of the marijuana users also had used one or more drugs other than hashish and alcohol. Of "pot" users, 40% had used two or more of the following: LSD, speed, heroin, dex, glue, cocaine, opium. Three or more of these drugs had been used by 25% of the marijuana users. Four or more had been used by 20% of the users. Most (84%) of the users had tried hashish.

Dr. Udell also found that there was a fairly definite pattern of drug use according to economic groups. There were relatively few users among students from low income groups and a disproportionately high number of users from the high income groups.

Clinic Managers Hold Fall Conference, B. R. Falls

The fall conference of the Wisconsin Clinic Managers Association was held October 23–24 in Black River Falls. Most of the 75 clinics in Wisconsin were represented at the two-day conference, according to William Wilcox, manager of the Krohn Clinic.

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MEETINGS AND SPECIAL EVENTS HELD AT THE STATE MEDICAL SOCIETY "HOME" DURING THE MONTH OF NOVEMBER 1971

2 Madison General Hospital Surgical Staff
2 Madison Urological Society
2 Madison Anesthesiology Society
2 Dane County Medical Society Board of Trustees
4 Wisconsin Joint Practice Commission
4 SMS Committee on Medicine and Religion
4 Madison Academy of Internal Medicine
4 Madison Area Otolaryngologists Seminar
11 SMS Division on Alcoholism and Addiction
12 Wisconsin Nutrition Council
13 Ad Hoc Committee on SMS Annual Meeting
15 Dane County Medical Society Insurance Advisory Committee
18 Executive Committee, SMS Council
18 Committee on Economic Medicine, SMS Council
18 SMS Council
18 AMA Delegates Caucus
18 Executive Committee, SMS Commisison on Medical Care Plans
18 Steering Committee, Health Care Task Force
23 Wisconsin Regional Medical Program Staff

Meetings not held in the Society "Home" but which have a direct relationship are printed in italics with the location in parentheses.

Craig L. Anderson, MD

. . . Green Bay, recently became associated with the medical staff of the Beaumont Clinic, Green Bay. Doctor Anderson received his medical degree from the University of Wisconsin Medical School in 1966 and served his internship and residency at Strong Memorial Hospital, University of Rochester, Rochester, N. Y. He also was chief resident and an instructor at the Hospital. Prior to joining the Clinic staff, Doctor Anderson served in the United States Air Force where he was officer in charge of pediatrics at Castle Air Force Base, Atwater, Calif.

D. C. Almazar, MD

. . . Wittenberg, recently opened his medical practice in the Wittenberg Medical Clinic. A graduate of the Far Eastern University in Manila, Philippines, he served an internship in Swedish Covenant Hospital, Chicago, and his residency at Ohio Valley General Hospital in West Virginia. Prior to coming to Wittenberg, he was at Swedish Covenant Hospital, Chicago, for a two-year residency in general practice.

C. Norman Shealy, MD*

. . . La Crosse, chief of neurosurgery at Gundersen Clinic, has left the Clinic and Lutheran Hospital staffs to open and direct a center at St. Francis Hospital in La Crosse for the rehabilitation of patients having chronic pain. Doctor Shealy will remain as a consultant at Lutheran Hospital. He has been associated with the Gundersen Clinic since 1966. He is a 1956 graduate of Duke University Medical School.

David Grout, MD

. . . Fort Atkinson, recently opened offices with MDs W. D. Moritz and F. E. Nichols, Stoughton. All three physicians have offices in Stoughton, Edgerton, and Fort Atkinson. A 1965 graduate of Ohio State Medical School, he spent a year serving his internship at Chicago Wesley Memorial Hospital; his residency in urology, for the past six years was taken at Wesley Memorial, Passavant Memorial, Children's Memorial, and Veterans Research hospitals.

Frederick J. Hofmeister, MD*

. . . Elm Grove, associate clinical professor, Department of Gynecology and Obstetrics, Medical College of Wisconsin, and Leslie Williams, MD, chief, Department of Obstetrics and Gynecology, Kingston Public Hospital, Victoria, Canada, recently were honored for their motion picture "Abdominal Hysterectomy."

Alex P. Avestruz, MD*
Nerissa Avestruz, MD*

. . . Spring Valley, recently attended the 23rd Annual Scientific Assembly of the American Academy of General Practice in Miami Beach, Fla.

J. Morton Schneider, MD*

. . . Madison, assistant professor in the department of gynecology and obstetrics at the University of Wisconsin and co-director of fetal-perinatal medicine, recently won first place in an exhibit entered at the American Society of Anesthesiologist's annual meeting held in Atlanta, Ga.

Leo G. Joseph, MD*

. . . former health officer for La Crosse, recently resigned as medical director of Hillview Home and Oak Forest to accept a position at California State Hospital, Camarillo, as a geriatric oriented internist. Doctor Joseph was the health officer of La Crosse from 1966–1970.

Dean A. Emanuel, MD*

. . . Marshfield, recently attended the 4th International Davos Symposium on Farmer's Lung and Aspergillosis held in Davos, Switzerland. Doctor Emanuel presented a program entitled "Clinical Functional and Anatomical Aspects of Farmer's Lung."

Derward Lepley, Jr., MD*

. . . Elm Grove, professor and chairman of the department of thoracic–cardiovascular surgery at the Medical College of Wisconsin, recently was appointed chairman of the Committee on Coronary Artery Surgery of the Inter Society Commission for Heart Disease Resources.

Floyd Detert Leaves Marshfield Clinic for Oconto Falls Post

Floyd R. Detert, manager of the Marshfield Clinic for more than 25 years, recently resigned his position to become manager of the newly organized Stanley Medical Center in Oconto Falls. The Center is under construction and will be opened next March. The Oconto County community also has under construction a new 106-bed hospital which is scheduled to open in January.

Mr. Detert, a past president of the National Medical Group Management Association, in an interview with news media said, "It has been a most pleasant and rewarding experience to have served the Marshfield Clinic and its patients over these many years." He further commented that he sees a challenge in helping the new medical group at Oconto Falls.

Named acting administrator of the Marshfield Clinic is William C. Matthews who has been its personnel manager since 1961. He assumed his new duties November 1 and will continue until the appointment of an executive director, at which time he will return to his personnel duties.

Two National Groups Join in Peer Review Program

Two national medical specialty organizations have joined together to offer a proficiency testing program to physicians with office laboratories.

The American Society of Internal Medicine and the College of American Pathologists have designed PEP (Proficiency Evaluation Program) specifically for monitoring the capabilities of the physician's office laboratory and for conducting an economical, comprehensive evaluation of his own test results.

Officials of the two groups emphasized that "participation in the proficiency testing program is entirely confidential." They said that the two specialty organizations decided to offer the program jointly as evidence of medicine's desire to establish peer review program for physicians that really works.

An invitation to join

AMERICAN PHYSICIANS ART ASSOCIATION

We would like to invite our medical colleagues to become members of our national non-profit organization which is dedicated to furthering art interests of the medical profession; to broadening the physician's knowledge and appreciation of the past and present; to stimulating physician artists to produce works of art in the fields of painting, sculpture, photography, graphic arts, design and creative crafts; to holding a national annual exhibition of physicians' art works; and to stimulating regional art exhibitions of physicians' works at local, state and specialty meetings.

Our art exhibit is held annually in conjunction with the annual meeting of the American Medical Association. The APAA has a membership which extends across the entire United States, Canada and Latin America. Every state in the Union is represented through a Regional Director. It is the hope of the APAA to establish a central photographic archive of its members' art works, to be used for year-round press and magazine publicity in the physicians' home towns as well as nationally.

You do not necessarily have to be currently engaged in any art activity to become a member. We also welcome the support of anyone interested in furthering physicians' art in America, as our organization is totally supported by the members and friends of the APAA. The types of membership are:

Life Sponsor Membership	$200.00
Sponsor Membership	30.00
Regular Membership	15.00
*Associate Membership	5.00

(* Associate membership is for medical students, interns, and residents.)

If you are interested in becoming a member, or if you wish further information, please contact the President of APAA, A. M. Gottlieb, MD, 3801 Miranda Avenue, Palo Alto, California 94304.

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Gerard M. Gerling, MD

. . . is now associated with the Gundersen Clinic, Ltd., and La Crosse Lutheran Hospital in the Department of Neurology. Doctor Gerling was born in St. Louis, Mo. He attended St. Louis University, St. Louis, graduating in 1961. He obtained his MD degree at the same university in 1966. Doctor Gerling served his internship at St. Louis University Group of Hospitals, St. Louis, from 1966 to 1967. He fulfilled his residency training at the University of Michigan Medical Center Hospital, Ann Arbor Michigan, from 1967 to 1970. From 1970 to the present he has been associated with the Baptist Memorial Hospital, Methodist Hospital, and Le Bonheur Children's Hospital, Memphis, Tenn.

Seuk B. Kang, MD

. . . a native of Korea, has become associated with the Gundersen Clinic, Ltd., and La Crosse Lutheran Hospital. Doctor Kang received his MD degree in 1959 from Kyungpook National University, Taegu, Korea, then served his internship at the Ravenswood Hospital Medical Center, Chicago, Ill., until 1966. He fulfilled his residency in general surgery at the Ravenswood Medical Center, Chicago, and the Carney Hospital, Boston, Mass., from 1966–1967. He also served a residency in anesthesia at Tufts–New England Medical Center, Boston, Mass., from 1968–1969. From 1969 to the present he has been a staff anesthesiologist and director of respiratory therapy at the New England Medical Center, Boston, and also an instructor of anesthesia at Tufts University School of Medicine, Boston.

Dr. Kang

Dr. Gerling

Richard Hong, MD*

. . . Madison, professor of pediatrics and medical microbiology at the University of Wisconsin Medical School, recently was appointed as associate dean for clinical sciences. He has been affiliated with the medical school faculty since 1969.

Peter A. Midelfort, MD*

. . . Eau Claire, recently was reelected to the Board of Governors of the American College of Surgeons.

E. Basil Jackson, MD*

. . . Milwaukee, chairman of Lutheran Hospital's department of psychiatry, Milwaukee, recently was the guest speaker at a meeting of the hospital auxiliary. He spoke on "Current Trends in Mental Health: Focus on Lutheran Hospital."

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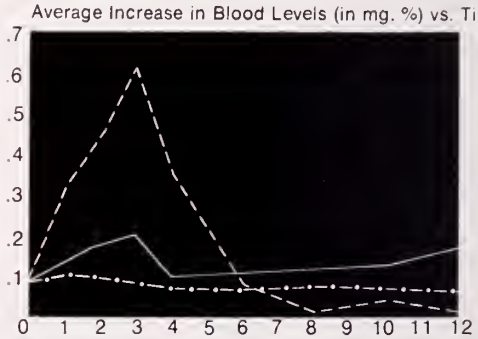

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MCW Student Awarded Surgical Scholarship, ICS

Kevin Turley, a medical student at the Medical College of Wisconsin, Milwaukee, has been awarded an undergraduate surgical scholarship by the United States Section of the International College of Surgeons (ICS).

The scholarship provides for a program in general surgery beginning in September at the University of Edinburgh in Scotland, under the direction of Mr. Ian B. Maclcod. This is part of the senior year curriculum in medical school and is approved by both the university and the ICS.

Mr. Turley, a 1968 graduate of Fordham University in New York, has just completed his junior year at the Medical College of Wisconsin. He is originally from Bronx, N.Y., where he attended St. Helena High School. □

CONTRIBUTIONS—CES FOUNDATION

October 1971

The Charitable, Educational and Scientific Foundation of the State Medical Society of Wisconsin is grateful to Society members, their various friends and associates, and other organizations interested in the aims and purposes of the Foundation, for their generous support. The Foundation wishes to acknowledge the following contributions for October 1971:

Nonrestricted

State Medical Society Members	Voluntary contributions of 15 MDs
Margaret C. Winston, MD	Contribution
Mrs. Robert W. Burns	Memorials: Mr. Milton Wickman, Mr. Gerald L. Kersten
E. J. Nordby, MD	Memorial: Wilbur R. Sachtjen
Joan Pyre	Memorial: I. M. Norsetter
R. M. Hammer, MD	Memorial: Mrs. Marion Albright
Dr. and Mrs. G. L. Rothenmaier	Memorial: George H. Smullen, MD
Carol Carden, Carol Davenport, Myrle Sturlaugson, Parks Reinhardt, Mr. and Mrs. David Beale, Margaret K. Pharo, Earl R. Thayer, and W. J. Brown	Memorial: Mrs. George LaBissoniere
Frances Ryan, Myrna Wichmann	Memorial: W. H. Witzel
State Medical Society	Memorials: G. M. Sargeant, MD, R. M. Kass, MD, C. O. Diamond, MD, B. A. Ruskin, MD, T. J. Kroyer, MD
Dane County Medical Society	Memorial: Karl K. Amundson, MD
The Cavills and Borens	Memorial: "Aunt Gustie"

Cyrus G. Reznichek, MD—Student Loan Fund

Staff at Jackson Clinic, Albert H. Stahmer Fdn, Inc., and Dane County Medical Society	Memorial: Cyrus G. Reznichek, MD

Medical Student Summer Externship Program

R. I. Reichle, MD	Contribution

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Mrs. Quincy Danforth	Contribution

Popp Student Loan Fund

Albert Popp, MD	Contribution

W. W. Hildebrand Memorial Account

William B. Hildebrand, MD	Contribution

Student Loans

State Medical Society Members	Voluntary contributions of 4 MDs

Charitable—Disabled Veterans

State Medical Society Members	Voluntary contributions of 2 MDs

Other Than CESF Projects

State Medical Society Members	Voluntary contributions of 3 MDs

Raymond G. Yost, MD*

. . . Manitowoc, recently was featured in the *Manitowoc Herald–Times* as having delivered all of his ten grandchildren. A general practitioner in Manitowoc for 36 years, he graduated from Marquette University School of Medicine (now Medical College of Wisconsin) in 1935.

Jerome J. DeCosse, MD

. . . Milwaukee, recently was elected to the Board of Governors of the American College of Surgeons. The widely known Cleveland (Ohio) cancer surgeon was recently appointed professor and chairman of the Medical College of Wisconsin's Division of Surgery and director of surgery for Milwaukee County General Hospital. His term is for three years.

Charles Awen, MD
Kim Chung, MD

. . . Oconto, recently were appointed to the medical staff of Oconto Memorial Hospital. Doctor Chung is a graduate of Yonsei University College of Medicine, Seoul, Korea. Doctor Awen, also a graduate of Yonsei University College of Medicine, is a pathologist on the medical staff of Bellin Memorial Hospital, Green Bay, and will be available on a consultation basis at Oconto.

Paul L. Karrmann, MD*

. . . Manitowoc, recently was awarded a fellowship in the American College of Obstetricians and Gynecologists. Doctor Karrmann, a member of the medical staff of the Manitowoc Clinic, is a graduate of Marquette University, Milwaukee, and served his internship at St. Mary's Hospital and residency at Milwaukee County General Hospital.

John P. Rahm, MD*

. . . Monona, director of emergency services at St. Mary's Hospital Medical Center, Madison, recently attended a medical assembly in Miami, Fla. Physicians, hospital administrators, nurses and other paramedical personnel met to exchange ideas on the practice of emergency medicine.

Sidney Shindell, MD*

. . . chairman of the division of preventive medicine at the Medical College of Wisconsin, Milwaukee, speaking to the National Council of Jewish Women in a study group meeting emphasized the importance of preventive medicine in today's society. He suggested the more widespread use of multiphasic screening programs.

Honorio G. Pineda, MD

. . . Menomonie, recently became associated with the Avestruz Clinic, Menomonie. Doctor Pineda graduated from the Far Eastern University, Manila, the Philippines and served his internship and residency at St. Barnabas Hospital (now Metropolitan Medical Center), Minneapolis. Prior to joining the Clinic, Doctor Pineda was associated with the approved preceptorship program in thoracic surgery and vascular surgery at St. Mary's Hospital, Minneapolis, Minn.

Teodoro Darvin, MD

. . . Shullsburg, is now the resident physician for Shullsburg. A graduate of Far Eastern University, Manila, the Philippines, he served his internship at Illinois Masonic Hospital, Chicago, and his residency training at Swedish Covenant Hospital, Chicago.

Richard K. Chambers, MD*

. . . Hartland, recently was named chief of the medical staff of Memorial Hospital, Oconomowoc. MDs Dean P. Epperson* and Charles B. Brummitt,* Oconomowoc, were named vice chief-of-staff and secretary–treasurer, respectively. □

Dr. Bernhardt Elected to Alumni Post

Election of Louis C. Bernhardt, MD,* Madison, as president-elect of the Wisconsin Medical Alumni Association has been announced by the association's board of directors. Dr. Bernhardt is a surgeon on the staff of the Dean Clinic.

He was elected in a mail ballot by association directors after the resignation of a president-elect named last May. Dr. Bernhardt has been a director of the organization, which is comprised of physicians trained at the University of Wisconsin Medical School, and University Hospitals, Madison.

Dr. Bernhardt

A native of Milwaukee, Dr. Bernhardt received his MD degree from Wisconsin in 1963. He interned at Mt. Sinai Hospital, Milwaukee, and served general surgery and thoracic and cardiovascular surgery residencies at University Hospitals, Madison. During this time he was chief resident and chief surgical resident. A diplomate of the American Board of Surgery, Dr. Bernhardt served with the 13th Evacuation Hospital of the Wisconsin Army National Guard for six years and was chief of its surgical service for two years.

Before joining the Dean Clinic this fall, Dr. Bernhardt was director of emergency room services at University Hospitals and also assistant dean for clinical affairs at the medical school.

Dr. Bernhardt will take over as alumni president in May 1972, succeeding John R. Petersen, MD,* medical director of Milwaukee County Institutions. □

Illinois Pediatrician Joins WRMP Staff

Paul C. Tracy, MD, a Park Ridge, Illinois, pediatrician since 1947, has joined the Wisconsin Regional Medical Program (WRMP) staff as Associate Coordinator for Program Development and Evaluation.

The announcement was made by Dr. John S. Hirschboeck,* WRMP Coordinator.

As associate Coordinator for Program Development and Evaluation, Dr. Tracy will be responsible for the supervision of the program development and evaluation staff as well as maintaining collaborative arrangements with the assistant coordinators appointed within the two medical schools in the Wisconsin Region.

A graduate of Loyola University School of Medicine, Dr. Tracy is on the staff of several hospitals in the Chicago area, most recently attached to Lutheran General Hospital, Park Ridge, Resurrection Hospital and Children's Memorial Hospital, Chicago. He has been very active in public education activities relating to health as well as taking an active role in various community-related organizations. He is a fellow member of the American Academy of Pediatrics and a past president of the Chicago Pediatric Society.

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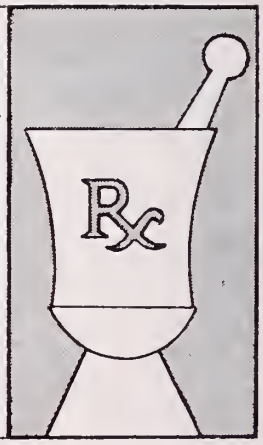

SOCIETY RECORDS

MEMBERSHIP REPORT AS OF NOVEMBER 22, 1971

NEW MEMBERS

Anderson, Craig L., 1821 South Webster Ave., Green Bay 54301
Axenrod, Howard, 1551 Dousman St., Green Bay 54303
Bae, Ik Hak, 1113 East Sumner St., Hartford 53027
Beddingfield, George W., 9800 West Bluemound Rd., Milwaukee 53226
Beres, Joseph A., 8700 West Wisconsin Ave., Milwaukee 53226
Bogunovic, Dragon, 8410 West Cleveland Ave., Milwaukee 53227
Bradke, Don Lee, 1751 Deckner Ave., Green Bay 54302
Browning, Thomas H., 5714 Odana Rd., Madison 53711
Buck, Roy E., 510 Doctors Court, Oshkosh 54901
DeCosse, Jerome J., 8700 West Wisconsin Ave., Milwaukee 53226
De La Fuente, G. Eduardo, Hollandale 53544
Dhaliwal, Kulwant S., 8700 West Wisconsin Ave., Milwaukee 53226
Downing, Edwin Lee, 515 Doctors Court, Oshkosh 54901
Elliott, Richard S., 126 South Main St., Seymour 54165
Fabric, Kenneth S., 1684 North Prospect Ave., Milwaukee 53202
France, Thomas D., 1300 University Ave., Madison 53706
Hattenhauer, John M., 614 First St., Wausau 54401
Hinz, William M., 1551 Dousman St., Green Bay 54303
Holmstrom, Robert D., 1720 North 8th St., Sheboygan 53081
Jan, Mazhar, 3533 E. Ramsey Ave., Cudahy 53110
Krautkramer, Ronald R., 2020 Santa Fe, Wichita Falls, Tex. 76309
Kuplic, James B., 1226 North 8th St., Sheboygan 53081
Lantis, Larry R., 110 East Main St., Madison 53703
Lantis, Sharon D. H., 1552 University Ave., #201C, Madison 53706
Lee, Alice M., Wausaukee 54177
Macachor, Jesus D., 8827 W. Rohr Ave., Milwaukee 53225
Malek, Gholam-Hossein, 1300 University Ave., Madison 53706
Maleki, Massoud, 6416 South Carroll Circle, Franklin 53132
Manabat, Enrique S., Jr., 621 East Walnut St., Green Bay 54301
Marasigan, Antonio Z., 1004 E. Sumner St., Hartford 53027
Mitra, Samir K., 8700 West Wisconsin Ave., Milwaukee 53226
Moritz, Walter D., 1206 Riverside Drive, Fort Atkinson 53538
Muriby, Nujud, 1300 University Ave., Madison 53706
Nunag, Armando N., 3533 E. Ramsey Ave., Cudahy 53110
Ravelo, Henry V., 620 North 19th St., Milwaukee 53233
Sapida, Arturo C., Walworth Medical Bldg., Walworth 53184
Skarphol, Darrell P., 835 South Van Buren, Green Bay 54301
Solidum, Ruben R., 135 South Main, Clintonville 54929
Troup, Charles W., 130 East Walnut St., Green Bay 54301
Tulecke, Jerome B., 12227 W. Dearborn Ave., Wauwatosa 53226
Vallejo, Walter J., 212 South 11th St., La Crosse 54601
Wilczynski, Joseph R., 5625 Washington Ave., Racine 53406
Wilson, Jeffrey W., 9191 W. Watertown Plank Rd., Milwaukee 53226

CHANGE OF ADDRESS

Becker, Robert M., 4015 Hammersley Ave., Madison 53705
Bellehumeur, Gerald C., 8185 North Green Bay Ave., Milwaukee 53209
Bernards, Walter C., 5145 SW Bancroft Ave., Portland, Ore. 97221
Blackwood, John S., 17000 West North Ave., Brookfield 53005
Broderick, Clifford F., 14038 Lake Forest Dr., Sun City, Ariz. 85351
Brooks, John R., 118 Virginia Rd., Glenwood Springs, Colo. 81601
Combs, James A., 515 22nd Ave., Monroe 53566
Curran, William P., 2821 South West 4th St., Boynton Beach, Fla. 33435
Dawes, Robert B., 9096 North 75th St., Apt. 1A, Milwaukee 53223
De Groat, Frank L., Jr., 5128 North Lake Dr., Milwaukee 53217
Flaherty, Gervase S., 13805 103 Way, Sun City, Ariz. 85351
Flint, Charles H., P. O. Box S, Minocqua 54548
Foreman, John W., 4701 Parkridge Dr., Racine 53402
Gryniewicz, Michael J., 3275 Applegate Lane, Brookfield 53005
Hisgen, William J., 2 Regis Circle, Madison 53711
Hobbins, William B., 121 South Pinckney St., Madison 53703
Jaeger, John G., 1836 South Ave., La Crosse 54601
Janis, Martin, 482 Cedar Hill Dr., San Rafael, Calif. 94903
Johnson, J. Martin, P. O. Box 36, 121 West Fond du Lac St., Ripon 54971
Kiernan, John H., Jr., 3920 Windsor Ave., Kansas City, Mo. 64122
King, James J., 6507 Betsy Ross Plank, Milwaukee 53213
Koch, Herman C., 145 East Moore St., Berlin 54923
Larson, Arthur N., Barney Children's Med. Center, 1735 Chapel, Dayton, Ohio 45404
Laubenheimer, Roger E., 15160 Kings Ridge Court, Brookfield 53005
McCay, Sophia P., 630 North Monroe St., Lancaster 53813
Mejia, Gualberto B., P. O. Box 166, Oxford 53952
Meyer, Ovid O., 1806 Summit Ave., Madison 53705
Nock, Gilbert J., Jr., 135 West Wells St., Suite 820, Milwaukee 53202
Olsen, Viggo B., 214 North Washington, Wheaton, Ill. 60187
Parks, Hyman K., 121 South Pinckney, Madison 53703
Pruscha, Calmon S., II, 888 Thackery Trail, Oconomowoc 53066
Roethke, Anne E., 4211 South Whithall Ave., Milwaukee 53207
Rueth, John E., 4081 North 97th St., Milwaukee 53222
Sanderson, Richard J., Route #3, Box 151, Hot Springs, Ark. 71901
Scerpella, Jaime R., 100 15th Ave., South Milwaukee 53172
Schofield, Raymond L., R. R. #2, Gillett 54124
Schuler, William H., 669 Thorne St., Ripon 54971
Shealy, C. Norman, 615 South 10th St., La Crosse 54601
Sisk, Ira R., 121 South Pinckney St., Madison 53703
Solidum, Ruben R., 135 South Main St., Clintonville 54929
Swingle, John D., 3701 Queens Ave., La Crosse 54601
Tasche, John A., 3350 S. Osprey Ave., Apt. #110A, Sarasota, Fla. 33579
Theisen, Charles E., 100 15th Ave., South Milwaukee 53172
Thompson, Frederic A., 725 American Ave., Waukesha 53186
Van Riper, Hart E., 440 A. Heritage Village, Southbury, Conn. 06488
Wagner, Philip C., 28 A Baltzell Gate Rd., Ft. McClellan, Ala. 36201
Wax, Robert E., 101 South Manchester Ave., Orange, Calif. 92668
Yutuc, Wilfrido R., 916 Cliffwood Lane, La Crosse 54601

DEATHS

Bucksdorf, Henry N., nonmember, Apr. 24, 1971
Lorne, John William, Eau Claire–Dunn–Pepin County, Oct. 4, 1971
Sheehan, Edward T., Milwaukee County, Oct. 11, 1971
Peterman, M. G., Milwaukee County, Oct. 14, 1971
Smullen, George H., Racine County, Oct. 19, 1971
Mathias, Ernest E. M., nonmember, Oct. 27, 1971
Sproule, Ralph T., Milwaukee County, Oct. 30, 1971
Barta, Edward F., Milwaukee County, Nov. 5, 1971
McGill, James W., Douglas County, Nov. 8, 1971
Stevens, George H., Marathon County, Nov. 9, 1971
Stovall, William D., Dane County, Nov. 18, 1971

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1. Latiolais, C. J., and Berry, C. C.: Misuse of Prescription Medications by Outpatients, *Drug Intelligence & Clin. Pharm.* 3:270-7, 1969.

TEST	HYPOTHYROID	SYNTHROID THERAPEUTIC NORMAL
P.B.I.	Less than 4 mcg %	6-10 mcg %
T_4 By Column	Less than 3 mcg %	7-9 mcg %
T_3 (Resin)	Less than 25%	27-35%
T_3 (Red Cell)	Less than 11%	11.5-18%
Free Thyroxine	Less than 0.7 nanograms %	0.7-2.5 nanograms %
Murphy-Pattee	Less than 2.9 mcg %	4-11 mcg %

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Unscored 5 mcg.	N.A.	N.A.	unscored ¼ gr.	¼ gr.	0.025 mg.
N.A.	½	½	unscored ½ gr.	½ gr.	0.05 mg.
25 mcg.	1	1	unscored 1 gr.	1 gr.	0.1 mg.
N.A.	N.A.	N.A.	N.A.	1½ gr.	0.15 mg.
50 mcg.	2	2	unscored 2 gr.	2 gr.	0.2 mg.
N.A.	3	3	unscored 3 gr.	3 gr.	0.3 mg.
N.A.	N.A.	N.A.	unscored 5 gr.	5 gr.	0.5 mg.
N.A.	N.A.	N.A.	N.A.	N.A.	Injectable 500 mcg.

N.A. = Not Available Commercially

*Equivalents shown are chemical, and do not take into consideration individual patient variables. Clinical effect is approximate and should be monitored when converting a patient to SYNTHROID. This is particularly important in patients previously on desiccated thyroid. In these patients, lower doses of SYNTHROID may produce the same metabolic effect.

**Euthroid (#1 tablet) contains 60 mcg. of T_4 and 15 mcg. of T_3.

***Thyrolar (#1 tablet) contains 50 mcg. of T_4 and 12.5 mcg. of T_3.

Synthroid®
(sodium levothyroxine)

Indications: SYNTHROID (sodium levothyroxine) is specific replacement therapy for diminished or absent thyroid function resulting from primary or secondary atrophy of the gland, congenital defect, surgery, excessive radiation, or antithyroid drugs. Indications for SYNTHROID (sodium levothyroxine) **Tablets** include myxedema, hypothyroidism without myxedema, hypothyroidism in pregnancy, pediatric and geriatric hypothyroidism, hypopituitary hypothyroidism, simple (nontoxic) goiter, and reproductive disorders associated with hypothyroidism. SYNTHROID (sodium levothyroxine) **for Injection** is indicated for intravenous use in myxedematous coma and other thyroid dysfunctions where rapid replacement of the hormone is required. The injection is also indicated for intramuscular use in cases where the oral route is suspect or contraindicated due to existing conditions or to absorption defects, and when a rapid onset of effect is not desired.

Precautions: As with other thyroid preparations, an overdosage may cause diarrhea or cramps, nervousness, tremors, tachycardia, vomiting and continued weight loss. These effects may begin after four or five days or may not become apparent for one to three weeks. Patients receiving the drug should be observed closely for signs of thyrotoxicosis. If indications of overdosage appear, discontinue medication for 2-6 days, then resume at a lower dosage level. In patients with diabetes mellitus, careful observations should be made for changes in insulin or other antidiabetic drug dosage requirements. If hypothyroidism is accompanied by adrenal insufficiency, as Addison's Disease (chronic subcortical insufficiency), Simmonds's Disease (panhypopituitarism) or Cushing's syndrome (hyperadrenalism), these dysfunctions must be corrected prior to and during SYNTHROID (sodium levothyroxine) administration. The drug should be administered with caution to patients with cardiovascular disease; development of chest pains or other aggravations of cardiovascular disease requires a reduction in dosage.

Contraindications: Thyrotoxicosis, acute myocardial infarction. **Side effects:** The effects of SYNTHROID (sodium levothyroxine) therapy are slow in being manifested. Side effects, when they do occur, are secondary to increased rates of body metabolism; sweating, heart palpitations with or without pain, leg cramps, and weight loss. Diarrhea, vomiting, and nervousness have also been observed. Myxedematous patients with heart disease have died from abrupt increases in dosage of thyroid drugs. Careful observation of the patient during the beginning of any thyroid therapy will alert the physician to any untoward effects.

In most cases with side effects, a reduction of dosage followed by a more gradual adjustment upward will result in a more accurate indication of the patient's dosage requirements without the appearance of side effects.

Dosage and Administration: The activity of a 0.1 mg. SYNTHROID (sodium levothyroxine) TABLET is equivalent to approximately one grain thyroid, U.S.P. Administer SYNTHROID tablets as a single daily dose, preferably after breakfast. In hypothyroidism without myxedema, the usual initial adult dose is 0.1 mg. daily, and may be increased by 0.1 mg. every 30 days until proper metabolic balance is attained. Clinical evaluation should be made monthly and PBI measurements about every 90 days. Final maintenance dosage will usually range from 0.2-0.4 mg. daily. In adult myxedema, starting dose should be 0.025 mg. daily. The dose may be increased to 0.05 mg. after two weeks and to 0.1 mg. at the end of a second two weeks. The daily dose may be further increased at two-month intervals by 0.1 mg. until the optimum maintenance dose is reached (0.1-1.0 mg. daily).

Supplied: Tablets: 0.025 mg., 0.05 mg., 0.1 mg., 0.15 mg., 0.2 mg., 0.3 mg., 0.5 mg., scored and color-coded, in bottles of 100, 500, and 1000. Injection: 500 mcg. lyophilized active ingredient and 10 mg. of Mannitol, N.F., in 10 ml. single-dose vial, with 5 ml. vial of Sodium Chloride Injection, U.S.P., as a diluent. SYNTHROID (sodium levothyroxine) **for Injection** may be administered intravenously utilizing 200-400 mcg. of a solution containing 100 mcg. per ml. If significant improvement is not shown the following day, a repeat injection of 100-200 mcg. may be given.

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BOOKSHELF

New books received are acknowledged in this section. From these books, selections will be made for reviews in the interest of the readers and as space permits. Reviews are written by members of the faculty of the University of Wisconsin Medical School and by others who are particularly qualified. Most books here listed will be available on loan from the Medical Library Service, 1305 Linden Drive, Madison, Wisconsin 53706; tel. 608/262–6594.

BOOKS RECEIVED

THE DOCTORS SHORTHAND

By Frank Cole, MD, Nebraska State Medical Journal. W. B. Saunders Company, West Washington Square, Philadelphia, Pa. 19105. 1970. 290 pages. Price: $4.95

MODERN TREATMENT, VOLUME 7, #5

Etiology, Diagnosis and Treatment of Multiple Sclerosis, Guest Editor: Gerard M. Lehrer, MD. Male Genital Infections, Guest Editors: Russell W. Lavengood, Jr. & John W. Draper, MD. Medical Department, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. $20.00 per year. Published bi-monthly. Sept. 1970

MOLECULAR PROPERTIES OF DRUG RECEPTORS

Edited by Ruth Porter & Maeve O'Connor. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 E. Preston St., Baltimore, Md. 21202. 1970. 298 pages

HANDBOOK OF OBSTETRICS AND GYNECOLOGY (Fourth Edition)

By Ralph C. Benson, MD, professor of Obstetrics and Gynecology and chairman, Department of Obstetrics and Gynecology, University of Oregon Medical School Hospitals and Clinics, Portland, Ore. Lange Medical Publications, Los Altos, Calif. 1971. 774 pages. Price: $6.50

HI, SUGAR!

By Vivian G. Lessel, B & B Publishing House, Tucson, Ariz. Distributors Thomas Nelson Inc., Copewood & Davis St., Camden, N. J. 08103. 1971. 183 pages. Price: $4.95

PHYSIOLOGY OF REPRODUCTION

By William D. Odell, MD and Dean L. Moyer, MD. The C. V. Mosby Co., St. Louis, Mo. 63103. 1971. 152 pages. Price: $12.00

SPEECH PATHOLOGY—An Applied Behavioral Science

By William H. Perkins. The C. V. Mosby Co., St. Louis, Mo. 63103. 1971. 449 pages. Price: $11.75

THE PINEAL GLAND

Edited by G. E. W. Wolstenholme and Julie Knight. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1971. 401 pages.

TEAMWORK FOR WORLD HEALTH

Edited by Gordon Wolstenholme and Maeve O'Connor. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1971. 242 pages.

ENERGY METABOLISM IN TRAUMA

Edited by Ruth Porter and Julie Knight. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1971. 202 pages.

PYROGENS AND FEVER

Edited by G. E. W. Wolstenholme and Joan Birch. Ciba Foundation Symposium, The Williams and Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1971. 232 pages.

CHEMICAL INFLUENCES ON BEHAVIOUR

Edited by Ruth Porter and Joan Birch. Ciba Foundation Study Group No. 35. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1970. 221 pages.

HORMONES AND THE IMMUNE RESPONSE

Edited by G. E. W. Wolstenholme and Julie Knight. Ciba Foundation Study Group No. 36. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1970. 172 pages.

HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY

Edited by G. E. W. Wolstenholme and Maeve O'Connor. Ciba Foundation Study Group No. 37. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1971. 220 pages.

THE FAMILY AND ITS FUTURE

Edited by Katherine Elliott. Ciba Foundation Symposium. The Williams & Wilkins Co., 428 N. Preston St., Baltimore, Md. 21202. 1971. 230 pages.

SYNOPSIS OF PEDIATRICS

By James G. Hughes, MD. The C. V. Mosby Company, St. Louis, Mo. 63103. 1971. 1141 pages. Price: $14.50

MODERN TREATMENT, VOLUME 7, #6

Management of Esophageal Disease, Guest Editor, Theodore M. Bayless, MD. Medical Department, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. $20.00 per year. Published bi-monthly. November 1970.

TONY'S SICKLE CELL CRISIS

By Sanford J. Brown and Peter Markus. Rapid Press, 128 E. Burleigh St., Milwaukee, Wis. 53212. 1971. 24 pages.

HANDBOOK OF PSYCHIATRY

By Philip Solomon, MD and Vernon D. Patch, MD. Lange Medical Publications, Los Altos, Calif. 1971. 648 pages.

THE MENTAL HEALTH OF THE CHILD

Program Reports of the National Institute of Mental Health. Superintendent of Documents, US Government Printing Office, Washington, D. C. 20402. June 1971. 588 pages. Price: $5.00

TEETH TEETH TEETH

By Sydney Garfield, DDS. Simon and Schuster Publishers. Rockefeller Center, N. Y. 1971. 448 pages. Price: $9.95

MODERN TREATMENT, VOLUME 8, #1

Legal Abortions in New York State, Guest Editor, George Schaefer, MD. Medical Department, Harper & Row, Publishers, 49 East 33 St., New York, N. Y. 10016. $20.00 per year. Published bi-monthly. February 1971.

SAVE YOUR HEALTH AND YOUR MONEY

By Patrick J. Doyle, MD. Acropolis Books, Colortone Building, 2400 17th St., N. W., Washington, D. C. 20009. 1971. 240 pages. Price: $6.95 (cloth) $3.95 (paper)

GENERAL OPHTHALMOLOGY

By Daniel Vaughan, MD, Taylor Asbury, MD, and Robert Cook, MD. Lange Medical Publications, Los Altos, California. 1971. 316 pages. Price: $8.00 □

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in the practice of medicine

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The views expressed in the articles on legal medicine are those of Society attorneys, or other authors, and do not necessarily represent Society policy; and in some cases represent areas in which no policy exists.

—Statement authorized by House of Delegates, Oct. 22, 1966

The "Blue Book"

SINCE 1924 the Wisconsin Medical Journal has published each January a "Blue Book" edition containing a variety of articles relating to medicolegal, socio-economic matters of direct concern to the physician in his relationship to patients, hospitals, governmental agencies, and others on the "health team." It is unique among medical journals of the United States.

In addition to Society membership, it is distributed gratis to senior and junior medical students of the two Wisconsin medical schools, and is available to others. It is particularly helpful to those who wish to become licensed physicians in Wisconsin.

The "Blue Book" is a useful reference book throughout the year. Physicians are urged to keep the Journal handy at all times.

Save Your "Blue Book" Issue For Future Reference

OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL—AMA

The Principles of Medical Ethics of the American Medical Association were condensed in 1957 to a preamble and ten sections. This preamble appears in this issue at page 9. Opinions of the Judicial Council interpreting the Principles are set forth in a booklet entitled, "Judicial Council Opinions and Reports: 1969." The booklet includes the jurisdiction and rules of the Judicial Council. Actions of the AMA House of Delegates relating to the Principles also are reproduced. This guide to good conduct is available upon request to the AMA, 535 North Dearborn Street, Chicago, Ill. 60610.

A Guide for Physicians, Hospitals and News Media

A guide to news relationships, jointly developed by the State Medical Society of Wisconsin, the hospital associations of Wisconsin and representatives of newspapers, radio and television, is certain to serve the public interest. The diverse nature of these groups is all the more reason to acknowledge the good to be accomplished by mutual understanding of the problems existing between them.

This guide is a product of many minds. In some respects it may seem elementary. Yet, in the long view it is hoped that the cub reporter and the new practitioner will find this guide a means to avoid unnecessary pitfalls while the older practitioner in either group will find it a constant reminder and a convenient aid.

This guide is not intended to supersede established local custom or guides which have developed out of local experience and practice.

A Joint Service Publication of

THE STATE MEDICAL SOCIETY OF WISCONSIN

THE HOSPITAL ASSOCIATIONS OF WISCONSIN

AND THE

NEWSPAPER, RADIO AND TELEVISION

ASSOCIATIONS OF WISCONSIN

JANUARY, 1971

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ORIENTATION

ALTHOUGH PHYSICIANS AND NEWSMEN conduct their respective practices in two quite different spheres, they have a mutual objective in the public good.

The physician is an individual concerned with an individual. His relationship with the patient is a sensitive, personal one. Whether in health or disease, the patient must receive care to the best of the physician's ability with the highest regard for ethics. The physician makes his decisions within the confines of ethical and professional standards established by his local medical society and the medical staff of the hospital in which he practices.

The newsman is part of an organization which has the world as its audience. His relationship with the reader is indirect, though often highly influential. The media usually are corporations, controlled by boards of directors and officers, with numerous departments to carry out their functions. News policies are entrusted to editors or news managers. In the case of newspapers, the city editor directs the reporters and passes on their stories before publication. Policy decisions concerning a particular story are made by the managing editor, executive editor, editor or publisher. Similar relationships exist in radio and television.

The newsman feels keenly the wide latitude given him by the United States Constitution, courts and customs in the name of freedom of the press. While the law holds the press accountable for what it does, there is a strong inclination to the principle that the public has a right to know. After all, vital decisions in a democracy are made by the public.

Thus, almost inevitably, there develops a clash between the "right to know" as viewed by the newsman on behalf of the public and the "right to privacy" as viewed by the physician on behalf of his patient. Both views have their place. Both practitioners are bound by established principles of ethics which have grown out of the traditions and requirements of their respective callings. It is clear that each must honor the natural commitments of the other.

This guide is an attempt to ease that relationship. It does not purport to resolve all questions and situations that arise in day-to-day contacts between physicians, hospitals and news media. It is simply a recognition that when the source of news is a doctor or his patient, or the hospital, the media assume an obligation to consider the life and health of the patient and recognize the ethics by which the doctor is bound. Further, it is a recognition that news media, as important social agencies, must report medical, scientific and educational news, and are entitled to the intelligent support of the medical profession and hospitals in the fulfillment of this obligation.

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Reprints of this guide are available upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; tel. (608) 257–6781.

PHYSICIANS AND NEWS MEDIA

In general, a physician is not permitted to disclose any information he may have acquired in professional contact with a patient, unless he has the express consent of the patient. In Wisconsin, willful betrayal of a professional secret is not only unethical but also illegal. Further, since the time of Hippocrates in 300 B.C., medical ethics have considered the doctor's knowledge of his patient as sacred as the confessional. Why? Because confidence inspires the sick to take steps necessary to restore themselves to health. A physician cannot intelligently care for the patient unless he is informed of all the facts, including those which the patient might not wish to have made known to his family, friends or community. Both the law and ethics let the patient know that, except for reasons more compelling than his own health, his secrets will be safe with the physician.

Thus, except in instances where a case must become part of a public record, the physician is not free to release any information about a patient, his illness or injury, without the patient's express consent. A consent is more likely to be held to be "express" if it is in writing.

News media are privileged to be the judges of what they present as news via newspaper, radio or television. Granting this, the physician is the only competent judge of the welfare of the patient in terms of health or disability. He alone can weigh the physical or emotional impact on his patient resulting from any invasion of his privacy.

HOSPITALS AND NEWS MEDIA

The community has a right to information about its hospital facilities and services not only because it is the hospital's function to serve the community, but also because it is the community in most cases which has helped to provide funds to create the hospital. It is the hospital's obligation to supply this information accurately, promptly and willingly.

To provide media with the opportunity to obtain information about a hospital, it is advisable that key hospital officials become acquainted with newspaper editors and reporters and with radio and TV news and public service programing department personnel.

Each hospital should name authorized spokesmen to be available at all times (24-hour per day coverage) to answer inquiries from news media. News media representatives should have the telephone numbers indicating where the appointed spokesmen will be available for information either day or night.

After naming spokesmen, the hospital staff should be informed that the task of handling news has been assigned to specific persons. Others on the staff should not release information but should refer all inquiries to those named to perform the news function.

Hospital telephone operators should be fully instructed to refer inquiries from news media to the authorized spokesmen—quickly, politely and efficiently. Spokesmen for the hospital should be impressed that news reporters usually need information quickly and that it is the hospital's duty to have such answers as soon as it is physically possible.

Information, as outlined and qualified on pages 5–7 of this guide, shall be provided by authorized spokesmen as rapidly as possible without interfering with the health, privacy or legal right of the patient, or without jeopardizing the hospital–patient relationship.

The physician must be guided by his patient's consent, except in cases in the public domain as outlined on page 6. The hospital's role is limited generally to the disclosure of facts which are already a matter of public record.

The physician will be guided by his professional code of ethics, the law, and other considerations of his local medical society or the hospital–medical staff itself. The role of the physician is clearly set forth in this guide. Hospital administrators should confer with their medical staffs regarding the hospital's news relations procedures and the physician's role in the application of this program.

On numerous occasions hospitals serve patients whose reputation or identity is newsworthy for one reason or another. Unless the admission of these patients is the result of an accident or police action, or is otherwise already a matter of public record, the hospital has no obligation to reveal any information about a patient to news media. Discretion in all such cases resides with the patient and with his attending physician. A hospital's primary concern is the physical and mental well-being of its patients. As much as possible, it must always respect the patient's right of privacy. At the same time, it must recognize that certain persons of prominence have placed themselves in the public domain to a greater extent than others. In light of this, information concerning treatment, diagnosis and general condition may be a public concern and may be released as outlined in the following pages.

Hospitals are bound by certain laws and regulations which make it impossible to give news media free access to all service areas or departments of the hospital building. This applies particularly to the maternity department and the operating room.

Information relative to research and scientific projects should not be released without the consent of the individual or individuals or the sponsoring agency involved. Such information may not be released in any manner to conflict with the ethics of the professional group concerned.

Information relative to the activities of the hospital, its procedures, equipment, facilities for treatment or other features of hospital service, may be provided by authorized spokesmen, although these spokesmen should refrain from making statements which indicate comparative advantage over other hospitals or which promote the personal advancement of any individual.

Emergencies which occur within the hospital should be communicated to news media quickly and frankly. Catastrophes such as fires, explosions, etc. are legitimate news items and the hospital will gain the respect and cooperation of the press by reporting these as candidly as it does news about research, donations and other positive activities.

PATIENTS IN THE NEWS

1. Private Patients:

A physician may not release news concerning a private patient, whether hospitalized or not, except with the express consent of the patient or some one authorized to speak for

him. Even though the media obtains news of such private patients from other sources, the doctor may not answer inquiries about his patient unless he has permission of the patient to speak.

However, the private patient of unusual prominence whose every activity is a matter of news interest forfeits to an undefinable degree rights of privacy generally afforded to less prominent persons. Public interest is said to override personal preference. While the physician must still obtain the consent of such a person, he has the added obligation of pointing out to the patient that his situation is likely to become known, if not already so, and that public acknowledgment of this fact will usually be in his best interest. In this way, he can be assured that information relative to his condition will come from authorized sources, thus avoiding embarrassment and irritation for all parties concerned.

When such a case is of serious public concern, the physician may arrange to issue daily bulletins on the patient's condition.

Public anxiety concerning unusually prominent patients often makes the name of the attending physician or physicians important, and these may be used in good taste and according to local medical society custom. Ordinarily, however, the name of the physician is not a relevant part of the attention given the patient.

2. Cases in the Public Domain:

Because certain events are required to be made a part of the public record or are a matter of concern to civil authorities, they shall be regarded as automatically released for publication. Physician participation in such releases enhances their accuracy. The media will appreciate the physician's effort to accelerate the release of such information within his ability to provide reasonable and accurate information.

Usually included in the category of cases in the public domain are legitimate births, deaths, accidents and police cases.

In such cases, the physician or hospital may release the following qualified information without the patient's consent:

Identity of the Individual (If Known):

a. Name, address, marital status, age, sex, occupation, employer, name of parents in case of births, name of next-of-kin in case of deaths and name of mortuary in case of deaths.

Nature of the Accident or Police Case:

a. Only general information regarding injuries will be released. This includes naming the injured portion of the body; e.g., the back, the head, the leg, etc. It may be stated that there were internal injuries. If the patient was unconscious when brought to the hospital, a statement to that effect may be made.
b. A statement may be made that the injury was caused by shooting, but no statement may be made as to how the accident occurred.
c. A statement may be made to the effect that the patient was injured by a knife or other sharp instrument, but no statement may be made as to whether it was assault, accidental or self-inflicted.
d. A statement may be made that the patient received burns and the member of the body affected may be indicated. A statement as to the degree of the burn and cause can be given only when the facts are known.
e. In cases of accidental poisoning, or death by poisoning, a statement may be made to the effect that a patient has been poisoned.
f. No statement shall be made that there was suicide or attempted suicide.
g. No statement shall be made to the effect that intoxication or drug addiction was involved.
h. No statement shall be made that moral turpitude was involved.
i. When incidents may reflect discredit on a patient or his family through such alleged circumstances as suicide or attempted suicide, intoxication, drug addiction, illegitimate birth, moral turpitude or rape, the physician is justified in withholding such details as a self-protection against damage suits. A preferred source of information is the police officer.

Patient's Condition:

A statement may be made as to the general condition of the patient by using the following classifications:

a. Minor injuries or similar general diagnosis
b. Good
c. Fair
d. Serious
e. Critical
f. Dead—In all cases of death physicians are urged, in cooperation with news media, to withhold release until the immediate relatives are notified if that be practical.

Inasmuch as a diagnosis may be made only by a physician and may depend upon x-ray and laboratory studies (sometimes time-consuming) no report of diagnosis may be given except by the attending physician or his authorized agent and then within the description outlined above under "2. Cases in the Public Domain."

As a consideration to patients and their families, the physician may not release the prognosis of a case.

3. Photographs:

Photographs have strong reader appeal and may be used in good taste. However, certain precautions are advised:

a. Photographs of police cases may be taken without the patient's consent and without either the news media or the physician incurring liability. However, the physician must reserve the right to refuse consent under certain circumstances such as when, in his judgment, the presence of photographers or reporters might aggravate the patient's condition, or when for other reasons judgment indicates discretionary action.
b. In all other cases the express consent of the patient and the attending physician is necessary before pictures can be taken. Where the patient is a minor, permission of the parents or guardian is required. This includes such non-news photographs as surgical or medical motion pictures or televised pictures.
c. Deceased or unconscious patients may not be photographed except in police cases.

d. Patients with severe burns or facial injuries, or other serious disfigurement, will generally not be photographed even though consent is obtained. Sound judgment and good taste must govern exceptions.

PHYSICIANS IN THE NEWS

1. County Medical Society:

The county medical society is the basic unit of medical organization. It has general direction of the affairs of the profession in the county and constantly exerts its influence for the moral and scientific improvement of every member physician and for the improvement of public health in the community. In this role, the county medical society supervises the ethical conduct of its members, and serves as the focal point for coordination of medical and health programs involving physicians with other segments of the public.

Among the functions of the county society, either through its officers or committees, is the interpretation of attitudes of the news media to the society and its individual physicians, and the attitudes of the society and its members to the news media.

The county society, through designated officers or committees, is urged to:

a. Advise the news media of the availability of spokesmen for the society as a whole or for problems which arise in specialized areas.
b. Be available to member physicians for advice on the handling of specific problems of news relationships.
c. Make itself available to news media for clarification of medical stories, local application of the subject matter, evaluation of scientific reports received by local news media, and adjudication of problems of physician–press relationships within the framework of this guide.

In relation to news originating in the county medical society the following guides are presented:

a. Information as to dates and the nature of regular meetings of the society shall be available. Since much of the business of the society relates to the affairs of a private organization, it is natural that the wishes of the society with regard to news media attendance be respected. Elections and committee appointments should be announced in timely fashion. News of society actions affecting the health and welfare of the community should be released by appropriate officers of the society. Items of peculiar community importance, such as epidemics and broad public health programs or problems, suggest particularly prompt, complete and careful presentation through appropriate officers. Physicians are reminded that enlightened publicity is a safeguard against misrepresentation, misunderstanding, ignorance and fear. However, in releasing information, it is wise to evaluate the relative merits of making a statement on the basis of fact or opinion.
b. When scientific programs are presented, the speaker shall be accessible to the news media, and every effort should be made to assist reporters in presenting such information in a fashion that can be understood by the non-medical person.

2. Scientific News:

The society should make itself available to comment, when requested, on scientific news coming into the community via wire or similar services. This may be a request to evaluate the report or localize the information. If a prompt response cannot be provided, the newsman should be so informed and the media urged to use the information later if waiting for a report is felt advisable. Every effort should then be made to provide a report as promptly as reasonable.

The society should cooperate, in accordance with local custom, in the presentation of news on rare or unusual disease, new or unusual treatments, and similar scientific developments on the basis that proper reporting of such information will lead to a better public understanding of the progress of medical science.

3. Individual Physician:

Identification of the physician by name and photograph in newspapers, magazine articles and on radio and television is a matter of established local custom. In general the following guides are presented:

a. As a private citizen, the physician is the subject of news stories on his personal, social and civic activities just as any other citizen. The use of the title "M.D." or "Dr." in identifying the citizen in such circumstances is wholly permissible since it is an earned degree from an accredited academic institution.
b. Physicians, as officers and committee members of the medical society, may be designated as spokesmen for the activities to which they have been assigned by the medical society and are then to be regarded as quotable sources by the news media.
c. Physicians may be quoted on matters of general interest not related to specific disease or the care of a specific patient. The association of a physician's name with the diagnosis or treatment of a specific disease infers that he can perform either or both of these services better than his colleagues and hence that he is an expert among his fellow physicians. This is normally considered to violate established ethical principles.
d. Physicians as scientists may discuss new treatments and diseases with the news media within the ethical customs of the local society.
e. The Doctor of Medicine, as the patient's personal physician, must fully respect the confidences he receives and may not release them except with the patient's consent and as outlined in the previous discussions of news of private patients and cases in the public domain.

Identification in the circumstances named above shall not be considered by the physician's colleagues as a breach of the time-honored practice of physicians to avoid publicity. In some instances it is done in the best interests of the public and the profession; in others it is done within the right of a private citizen. However, repeated appearances of a physician's name, or the name of a physician-owned clinic or hospital, will raise ethical questions if continued over an extended period.

Whenever the physician is in doubt, he is urged to seek the advice of his county society (officers or public relations committee chairman) or the State Medical Society.

HEALTH EDUCATIONAL EFFORTS

Educational efforts involving health or medicine may be distinguished from what is regarded as "news" in the strict sense, and thus requires special comment. Health education may require use of columns or special articles in newspapers and magazines and live or recorded presentations on film, radio or television.

The duty and responsibility of physicians to participate in proper health education programs has been positively stated by the American Medical Association and the State Medical Society of Wisconsin on several occasions.

The medical profession generally considers it ethical for a physician to meet the request of his local medical society to write or speak for general readers or audiences. On the other hand, the news media may be the first to perceive the adaptability of medical information for public presentation. This may result in the physician being requested to release certain information.

A physician who desires to know whether, ethically, he may engage in a project aimed at health education of the public should request the approval of the designated officer or committee of his county medical society, first to assure that the information to be presented will be regarded as acceptable public health advice by the profession as a whole, and second to protect the physician from any charge of self-aggrandizement.

No presentation on a scientific or health education subject can be fully successful without physicians identified by name because people will not take authoritative advice from a nonentity. Neither should they be encouraged to do so.

In light of these facts, the following criteria are recommended for participation by physicians in health educational programs on radio and television, whether sustaining or sponsored:

a. Appointment of physicians by the medical society safeguards any program and any individual from charges of excessive frequency of participation on radio or television programs. Over a period of time, every physician gets approximately equal opportunity unless he declines to participate.

   No physician should appear twice on one program, or one program series, until all those eligible and willing have taken part at least once. An exception may be made in case the physician is not in the private practice of medicine and his appearances are approved by the appropriate officials or committee of the county medical society.

   Any member of the county medical society who is invited or desires to participate in any radio or television program, be it on a sustaining or sponsored program, should clear that appearance with the appropriate officers or committee of the society.

b. Practicing physicians participating in radio or television programs may be identified by name, city and field of practice only. The home or office address shall not be designated. If the physician is a public official, full time professor, or not otherwise in the usual practice of medicine, one simple item of identification by title is proper. In the event the physician is an officer of his constituent medical society or his constituent specialty organization or a recognized voluntary health organization, his association with such an organization may be used to further identify him.

c. Physicians participating in radio or television programs should be identified by simple title or association rather than by fulsome praise.

d. Program format in productions sponsored by the county society, as such, should be limited to situations typical of the relationship between the practicing physician and the patient. Such programs shall be carefully limited with respect to description of treatment because the major purpose of the program is to educate the patient in recognition of symptoms, not in the details of treatment. Anything that tends to stimulate self-treatment should be avoided. Likewise, in presentation of information on conditions or ailments which offer one or more methods of treatment, care should be taken not to prejudice the listener to one specific type of treatment. The patient's physician must always be the judge of choice of treatment.

e. All correspondence resulting from radio or television programs should be routed through the proper county medical society channel* so that a consistent pattern can be developed for answering inquiries.

f. Try to avoid statements which indicate that adequate care for certain conditions or ailments is available only from certain specialists, clinics, hospitals or the like; avoid implications that certain kinds of treatment are not acceptable or that one treatment is better than another. The public does not relate such matters to the problems of the individual patient, but is inclined to accept such statements as criteria to judge their own physicians.

Many of the radio and television programs upon which physicians may be requested to appear are presented without commercial sponsorship as public service features. Similarly, most stations are willing to make available desirable time without charge as a public service when the local medical society is interested in presenting wholly health educational material for public consumption.

Use of and participation in sponsored time is completely acceptable and ethical providing the medical society retains control over the content of the program proper, and it is satisfied that the sponsorship in conjunction with the program is acceptable. The American Medical Association has well established and time tested policies for participation in medical programs on sponsored time and these should be used as a guide in establishing such a relationship.

The above criteria apply equally to health educational articles in newspapers and magazines.

** The county medical society may always refer questions to the State Medical Society for advice and assistance.*

THE NEWS MEDIA AND THE MEDICAL PROFESSION

Deadlines are an essential daily routine to the news media. Therefore, it is vital that information be furnished, if at all possible, at the time requested. If information is promised and unavoidable delays are encountered, the media should be so advised. At the same time, newsmen must recognize that accurate information concerning a patient's condition may not be readily ascertainable and requests about a highly technical medical subject may require serious study before public comment.

Equal access should be given all media to information of general news interest. If a newspaper or other medium, as a result of its own initiative, obtains an exclusive story, the right to that exclusive should be respected to the extent that no effort should be made to give the story to another agency before release by the first. However, should another medium approach the physician or medical society about the same story, it is obligated to release the information to that agency as well.

News media have a right of ready access to properly authorized spokesmen for the medical society at any time. Unless otherwise designated to the media, it can be assumed that officers of the county medical society and the members of its public relations committee are properly authorized spokesmen.

Editors of newspapers and news directors of radio and television stations have a responsibility to protect the names of individuals by verifying information that may be derogatory and giving one party to any controversy the opportunity to rebut statements made by the other. As a protection to their own organizations, such persons must be well schooled in questions of liability. This is also a protection to the physician and the medical society.

Reticence to respond to media inquiries often is the reason for inaccurate or incomplete news reporting. When a physician hesitates to discuss certain matters with a reporter, it may be advisable to contact the newspaper editor or news director of radio or television for a full and frank discussion of the problem. Development of trust and understanding between physicians and news media is mutually beneficial and in the best public interest. This can be fostered by periodic meetings between county medical societies and representatives of the news media.

In the event problems of substantial consequence develop between any of the parties to news relationships which do not remedy themselves by personal understanding between the parties, each should feel free to refer the problem to the medical society or news media association of which he is a member.

PRINCIPLES OF MEDICAL ETHICS OF THE AMERICAN MEDICAL ASSOCIATION

Preamble

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principle objective of the medical profession is to render service to humanity with full respect for the dignity of man. Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and well-being of the individual and the community.

Adopted June 7, 1957

CANONS OF JOURNALISM

American Society of Newspaper Editors

The primary function of newspapers is to communicate to the human race what its members do, feel, and think. Journalism, therefore, demands of its practitioners the widest range of intelligence, of knowledge, and of experience, as well as natural and trained powers of observation and reasoning. To its opportunities as a chronicle are indissolubly linked its obligations as teacher and interpreter.

To the end of finding some means of codifying sound practice and just aspirations of American journalism these canons are set forth:

I. *Responsibility*

The right of a newspaper to attract and hold readers is restricted by nothing but considerations of public welfare. The use a newspaper makes of the share of public attention it gains serves to determine its sense of responsibility, which it shares with every member of its staff. A journalist who uses his power for any selfish or otherwise unworthy purpose is faithless to a high trust.

II. *Freedom of the Press*

Freedom of the press is to be guarded as a vital right of mankind. It is the unquestionable right to discuss whatever is not explicitly forbidden by law, including the wisdom of any restrictive statute.

III. *Independence*

Freedom from all obligations except that of fidelity to the public interest is vital.

1. Promotion of any private interest contrary to the general welfare, for whatever reason, is not compatible with honest journalism. So-called news communications from private sources should not be published without public notice of their source or else substantiation of their claims to value as news, both in form and substance.
2. Partisanship in editorial comment which knowingly departs from the truth, does violence to the best spirit of American journalism; in the news columns it is subversive of a fundamental principle of the profession.

IV. *Sincerity, Truthfulness, Accuracy*

Good faith with the reader is the foundation of all journalism worthy of the name.

1. By every consideration of good faith a newspaper is constrained to be truthful. It is not to be excused for lack of thoroughness or accuracy within its control or failure to obtain command of these essential qualities.
2. Headlines should be fully warranted by the contents of the articles which they surmount.

V. *Impartiality*

Sound practice makes clear distinction between news reports and expressions of opinion. News reports should be free from opinion or bias of any kind.

This rule does not apply to so-called special articles unmistakably devoted to advocacy or characterized by a signature authorizing the writer's own conclusions and interpretations.

VI. *Fair Play*

A newspaper should not publish unofficial charges affecting reputation or moral character without opportunity given to the accused to be heard; right practice demands the giving of such opportunity in all cases of serious accusation outside judicial proceedings.

1. A newspaper should not invade private rights or feelings without sure warrant of public right as distinguished from public curiosity.
2. It is the privilege, as it is the duty of a newspaper to make prompt and complete correction of its own serious mistakes of fact or opinion, whatever their origin.

VII. *Decency*

A newspaper cannot escape conviction of insincerity if while professing high moral purpose it supplies incentives to base conduct, such as are to be found in details of crime and vice, publication of which is not demonstrably for the general good. Lacking authority to enforce its canons, the journalism here represented can but express the hope that deliberate pandering to vicious instincts will encounter effective public disapproval or yield to the influence of a preponderant professional condemnation.

Publishers, as well as editors, should appreciate and be willing to apply the tenets of such a code. In addition, the publishers at the helm in their respective offices need to enforce rules insuring honest advertising, fair competition, sound circulation, and fair treatment and opportunity for the men and women who cooperate as employes to make journalistic enterprises serviceable to intelligent citizenship.

Adopted in 1923

LET THESE GUIDES HELP YOU

The following guides and manuals have been prepared at the direction of a number of councils, commissions, divisions, and committees of the State Medical Society to be of direct personal assistance to the physician or his county society. Each is available without cost upon request to the State Medical Society office, Box 1109, Madison, Wis. 53701.

1. **Interprofessional Code**
2. **Guide to the Service Corporation Law**
3. **Code of Necropsy Procedure**
4. **Hearing Conservation Programs for Wisconsin Industries**
5. **Occupational Health, A Guide for Medical and Nursing Personnel**
6. **Find Your Future in the Health Field**
7. **Guide to Immunization Planning**
8. **Inspection of Medical Records**
9. **Principles for Transporting the Ill and Injured**
10. **School Vision Screening Program**
11. **First Aid Chart**
12. **Guide to Interpretation of Chapter 484, Laws of Wisconsin, 1959**

The Right to Use the Title "Doctor" in Wisconsin

HISTORICALLY, the title "doctor" has been conferred upon those who have become so well versed in a particular field of knowledge that recognized schools of higher education regard them as qualified to teach the subject. Among the long-established doctoral degrees are those in medicine, dentistry, divinity, law, science, philosophy, letters and music.

TRADITIONALLY, when the treatment of the sick was involved, the title "doctor" has referred to the doctor of medicine.

The legal right to use the title "doctor" outside the field of treating the sick is not discussed. Obvious examples are doctors of divinity, veterinary medicine, or philosophy, so long as none of them is engaged in "treating the sick," as this term is defined in Wisconsin.

THE WISCONSIN statutes and court interpretations are controlling on who may use the title "doctor" when "treating the sick."

The following is a summary of the present law of Wisconsin as it applies to use of the title "doctor" when engaged in "treating the sick." This is accompanied by brief references to the legal authority supporting the conclusions. It is assumed in each instance that the practitioner has fulfilled licensure or other requirements imposed by Wisconsin law.

Subsections (a) and (b) of Sec. 445.01 (1) of the Wisconsin Statutes, provide:

"(a) To "treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.

(b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts."

LEGAL AUTHORITY

The following is a summary of the principal statute or court decision which is the basis of the conclusions reached in the chart below and which follows the same order as the chart:

1. **Physician:** The right of a doctor of medicine to use the title without restriction is conferred by Sec. 448.02 (3), Wisconsin Statutes, which provides:

"(3) No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under s. 448.06, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M.D." "D.O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick."

2. **Osteopath:** Controlled by the above subsection and, therefore, unlimited.

3. **Dentist:** The right of a licensed doctor of dental surgery to use the title without restriction is conferred by Sec. 447.02 (1), Wisconsin Statutes, which provides in part:

"(1) Any person who was lawfully engaged in the practice of dentistry in this state on January 1, 1939, may so continue if he has registered annually. . . . No other person shall practice dentistry in this state, unless he is licensed by the board and annually registered in this state. . . . Any person is deemed to be "practicing dentistry" within the meaning of this chapter who . . . uses or permits to be used, directly or indirectly, for a profit or otherwise for himself, or for any other person, the title or appends to his name the words

SUMMARY OF WISCONSIN LAW ON USE OF TITLE "DOCTOR"

Practitioner	Unrestricted Right to Public Use	No Right to Public Use When Treating Sick
1. Physician	X	
2. Osteopath	X	
3. Dentist	X	
4. Podiatrist (Chiropodist)	X	
5. Chiropractor		X
6. Optometrist		X
7. Psychologist		X
8. Doctor of Philosophy (when treating the sick)		X

or letters "doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," or "D.M.D.," or any other letters, titles, degrees, terms or descriptive matter, personal or not, which directly or indirectly represent him to be engaged in the practice of dentistry. . . ."

4. **Podiatrist:** (Chiropodist) The right of a registered podiatrist to use the title without restriction is conferred by Sec. 448.10 (2), Wisconsin Statutes. This provides in part:

"(2) No person shall practice podiatry, for compensation, directly or indirectly, or in the expectation thereof, or attempt to do so, or designate himself as a licensed podiatrist, or use the title "D.S.C.," "Dr.," or "Doctor of Surgical Chiropody," or "Doctor of Podiatry," or "Doctor," or "foot doctor," or "foot specialist" or other title or letter indicating that he is a podiatrist, or otherwise directly or indirectly represent or hold himself out as such, unless registered by the state board of medical examiners . . ."

5. **Chiropractor:** No statute relating to chiropractic authorizes the use of the title "doctor" or initials "Dr." or "D.C." by a chiropractor. The illegality of the use of either the title or the initials "D.C." is based upon Sec. 448.02 (3) quoted earlier in Section 1. of this article, inasmuch as chiropractors "treat the sick."

In *State v. Michaels* (1938) 226 Wis. 574, the Supreme Court, in an opinion written by Chief Justice Rosenberry, forbade a chiropractor to use the title "doctor." The opinion stated, at pages 578 and 579, that since 1881 the use of the word "doctor" had been restricted by the Wisconsin legislature, and that the right to use the term had become associated with those entitled to practice medicine, surgery, and after 1903 osteopathy.

With reference to the statute regulating chiropractic, which was amended in 1925 to require licensure, the court stated at page 579 of the above opinion:

"The statute was rewritten and revised to make it clear that those practicing chiropractic could not hold themselves out as a doctor or append to their names the title of doctor because, in Wisconsin at least, that would tend to represent them as a doctor authorized to practice medicine, surgery, or osteopathy."

6. **Optometrist:** An optometrist practicing in Wisconsin is *not* entitled to use the word "doctor," the title of "Doctor of Optometry," or the initials "O.D." in the course of his practice. Chapter 449 of the Wisconsin Statutes deals with optometry. It is completely silent on his right to use the title or any variation of it. Authority must, therefore, be sought outside that chapter. In *Nickell v. State* (1931) 205 Wis. 614, at pages 617–618, the Supreme Court held that the examination of human eyes by various mechanical means constituted "treating the sick" under the Wisconsin Statutes. That decision has not been modified by subsequent opinions of the Supreme Court, or by later legislation. The essence of the practice of optometry is the examination of human eyes by such mechanical means. Therefore, the use of the title is controlled by and forbidden under Sec. 448.02 (3), Wisconsin Statutes, quoted in Section 1. of this article.

7. **Psychologist:** Chapter 445, Wisconsin Statutes, adopted in the 1969 session of the State Legislature, provides for the licensure of psychologists. Nothing is contained in this law which would permit a licensed psychologist to use the title "doctor" in treating the sick.

8. **Doctor of Philosophy:** There is no Wisconsin court decision authorizing *any* doctor of philosophy, including a psychologist, to make public use of his title when treating the sick. It is clearly controlled and prohibited by the provisions of Sec. 448.02 (3) quoted in Section 1. of this article.

As the Rosenberry opinion stated so appropriately as to the use of the title "doctor" by chiropractors in the *Michaels* case, cited in Section 5. of this article, at page 580 of that decision:

"The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment."

In the somewhat earlier case of *Corsten v. Industrial Commission* (1932) 207 Wis. 147, the court concluded its discussion of the meaning of Sec. 448.02 (3), quoted earlier, with the following sentence which appears at page 149 of the decision:

"Thus these names and letters may be applied only to those who are licensed as physicians to practice medicine and surgery, and conversely those to whom the names and letters may not be applied are not physicians."

POST MORTEM EXAMINATION

Question: Whose consent is required to permit a physician to conduct a post mortem examination?

Answer: Except for those cases in which an autopsy is ordered in connection with a proposed coroner's inquest, permission for a physician to conduct a post mortem examination requires the consent of the person who assumes custody of the body for burial, providing he is one of the following: father, mother, husband, wife, child, guardian, or next of kin.

If none of these is available, consent may be given by a friend or person charged by law with the responsibility for burial. If two or more such persons assume custody of the body, the consent of either one is sufficient.

Reference: Sections 155.05 and 966.121, Wisconsin Statutes.

Problems of a Physician's Widow

FOLLOWING the loss of one of its members by death, it has long been the practice of the State Medical Society to write the physician's widow in an effort to provide some advice during a trying period. The Society, believing that "an ounce of protection is worth a pound of cure," suggests that every member give thoughtful consideration to some of the problems which are likely to face a physician's widow. Careful preparation for such eventualities not only protects the family, but eases its burdens at a trying time.

Following the death of a physician, the widow will be faced with many decisions involving the settlement of the business affairs relating to her late husband's practice. It is of extreme importance that she act upon the advice of an attorney. When practical it is recommended that the physician acquaint his wife with his legal and other advisors and some of his business affairs. This will provide an established working business relationship between the wife and the advisors for that eventuality when she is called upon to act. Some of the chief problem areas the widow will face are outlined in the remainder of this article.

Former patients may seek a continuation of medication prescribed by the deceased physician. This must never be permitted except on advice of another physician because of the possibility of rapid change in the condition of the patient and resultant possible cause for legal action in the event unexpected results stemmed from continued use of the medication.

The widow will also be presented with the problem of what to do with the physician's narcotics. The Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a recent communication to the State Medical Society:

> "The deceased physician's Special Tax Stamp, unused Government order forms, and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused Government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wis. 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director, Bureau of Narcotics and Dangerous Drugs, Suite 1700, Engineering Building, 205 West Wacker Drive, Chicago, Ill. 60606, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to the Bureau of Narcotics and Dangerous Drugs."

It is important that a widow, other members of the family, and the attorney see to it that there is full and prompt compliance with the requirements of the above communication.

Instructions on the disposal of non-narcotic drugs in the possession of the physician at the time of his death may be obtained from the Wisconsin Pharmacy Examining Board, 110 North Henry St., Madison, Wis. 53703.

Records relating to patients, including case histories, treatment records, x-rays, laboratory reports, correspondence with physicians and others should *not* be destroyed for at least six years after the physician's death. Liability for malpractice and some other claims do not cease upon the death of a physician.

The physician's records and liability insurance policies may be the widow's chief sources of defense. Every precaution should be taken to insure that all such basic materials are kept intact and subject to immediate call for at least six years. The family attorney will be able to tell when they are no longer needed for this purpose.

The widow can expect that the deceased physician's patients will seek care elsewhere unless he had one or more associates. Sometimes the new physician will find it necessary for adequate treatment to obtain a copy of the previous physician's record of care of his patient. In such event, it is wise to insist upon a written request from the patient and his new physician. A copy of the record, with a covering letter may then be sent. A copy of the forwarding letter should be inserted in the original patient's file for future reference.

A decision may be made to sell the deceased physician's practice. The items to be included in the sale will vary with the nature of the practice, the amount of equipment involved and the wishes of the buyer.

To avoid complications, the widow should make sure the buyer is a physician licensed in Wisconsin. This information can be obtained from physician acquaintances or the State Medical Society. Records relating to patients should *not* be sold. However, the sale may include, as one of its terms, unlimited access to the records of those patients who seek the services of the purchasing physician. The widow's legal and other advisors can best inform her how to arrange the sale.

The collection of the deceased physician's professional accounts is another important matter. She should carefully follow her attorney's advice before bringing suit, since a patient can counterclaim for malpractice within three years. Ordinarily it is not desirable for a widow or the heirs to enforce collection by suit within such period. She should also seek legal and accounting advice on how long to retain the financial records of her late husband. It is quite possible that his estate may be subjected to audit by the state or federal income tax authorities. The retention of complete records is essential in anticipating such possibility.

The State Medical Society office is always available for consultation with a widow, her family or the estate attorney.

MUST A
Wisconsin Physician Report?

1. **Deaths?**
   The Wisconsin Statutes require that the following deaths must be reported *immediately* to the sheriff, police chief, or coroner of the county in which such death occurred:
   a. All deaths in which there are unexplained, unusual, or suspicious circumstances.
   b. All homicides.
   c. All suicides.
   d. All deaths following an abortion.
   e. All deaths due to poisoning, whether homicidal, suicidal or accidental.
   f. All deaths following accidents, whether the injury is or is not the primary cause of death.
   g. When there was no physician in attendance within 30 days preceding death.
   h. When a physician refuses to sign the death certificate.

   Violations of the above are punishable by fine or imprisonment.

2. **Treatment of automobile accident injuries?**
   No, unless there is a death.

3. **Drowning?**
   Yes.

4. **Gun shot wounds?**
   No, except where death results.

5. **Hunting accidents?**
   No, except where death results.

6. **Industrial accidents?**
   No, except where death results.

7. **Industrial diseases?**
   Yes, to the Division of Health, Department of Health and Social Services for diseases as required by statute.

8. **Suicide attempts?**
   No; only death by suicide is reportable.

9. **Sending of corpses to undertaker?**
   Yes. *Before* a physician sends a corpse to a funeral director, undertaker, mortician, or embalmer, he *must* notify the next of kin or a person who may be chargeable with the funeral expenses. There is a penalty for violation of this requirement.

10. **Live births?**
    Yes, you must file with the city health officer or county register of deeds, as appropriate, a certificate for all births attended by you within five (5) days. Failure to file within the time period makes fees for medical services unlawful.

    Additionally, the physician must separately report congenital defects or physical deformities of a newborn observed within 24 hours of birth. Such cases are reportable to the Division of Health, Department of Health and Social Services.

11. **Communicable diseases?**
    Yes, to local health authorities, except for polio which must be reported locally and to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702.

12. **Venereal diseases?**
    Yes, to the Division of Health, Department of Health and Social Services, 1 West Wilson Street, Madison, Wisconsin 53702. Patients delinquent in reporting for treatment must also be reported to the Division.

13. **Cancer?**
    Yes.

14. **Tuberculosis?**
    Yes, to your local Board of Health.

15. **Chronic alcoholics?**
    No, even if you know or believe it probable that they are driving automobiles.

16. **Epileptics?**
    No. But see article on page 68 of this issue.

17. **Drug addiction?**
    No.

18. **Abused children?**
    Yes. See article in January 1970 "Blue Book" issue of WISCONSIN MEDICAL JOURNAL at page 25.

The foregoing list incorporates questions most commonly asked, and is by no means a complete list of all that the statutes or department rules of the state require by way of reports from physicians.

The 1971 Wisconsin Legislature

DIRECTORY OF MEMBERS

Prepared by the Wisconsin Taxpayers Alliance
335 West Wilson Street
Madison, Wisconsin 53703

1971 Wisconsin Senate

State Officers

Governor—LUCEY, PATRICK J. (D), 1015 Farwell Court, Madison 53704

Lt. Governor—SCHREIBER, MARTIN J. (D), 3128 N. 50th St., Milwaukee 53216

Sec. of State—ZIMMERMAN, ROBERT C. (R), 4502 Hammersley Rd., Madison 53711

State Treasurer—SMITH, CHARLES P. (D), 509 S. Spooner St., Madison 53711

Attorney General—WARREN, ROBERT W. (R), 209 Glacier Dr., Madison 53705

Members of Congress from Wisconsin

SENATORS

State Office Bldg., Washington, D.C. 20510

PROXMIRE, WILLIAM (D), 4613 Buckeye Rd., Madison 53716

NELSON, GAYLORD (D), 5750 Bittersweet Pl., Madison 53705

REPRESENTATIVES

House Office Bldg., Washington D.C. 20515

Dist.

1. ASPIN, LES (D), 1814 College Ave., Racine 53403
2. KASTENMEIER, ROBERT W. (D), 300 N. Water St., Watertown 53094
3. THOMSON, VERNON W. (R), 578 E. 2nd St., Richland Center 53581
4. ZABLOCKI, CLEMENT J. (D), 3245 W. Drury La., Milwaukee 53215
5. REUSS, HENRY S. (D), 2400 E. Bradford Ave., Milwaukee 53211
6. STEIGER, WILLIAM A. (R), 645 Wisconsin St., Oshkosh 54901
7. OBEY, DAVID R. (D), 515 N. 9th Ave., Wausau 54401
8. BYRNES, JOHN W. (R), 406 N. Washington St., Green Bay 54301
9. DAVIS, GLENN R. (R), 3790 S. Center Rd., Waukesha 53186
10. O'KONSKI, ALVIN E. (R), Rt. 1, Rhinelander 54501

Members of the 1971 Wisconsin Senat

Dist.	Name (Party)	District (Counties)	Address
1.	Martin, Jerome A. (D)	Door, Kewaunee, Manitowoc	Box 6, Whitelaw 54247
2.	—Lotto, Myron P. (R)	1st, 2nd assembly districts, Brown; Calumet	R. 3, Green Bay 54301
3.	* Kendziorski, Casimir (D)	11th, 12th, 14th assembly districts, Milwaukee	2025 S. 14th St., Milwaukee 53204
4.	—Soik, Nile (R)	3rd, 18th, 25th assembly districts, Milwaukee	6266 N. Santa Monica Blvd., Whitefish Bay 53217
5.	* Schuele, Wilfred (D)	2nd, 9th, 15th assembly districts, Milwaukee	3036 N. 84th St., Milwaukee 53222
6.	Vacant	1st, 5th, 7th assembly districts, Milwaukee	
7.	Frank, Kurt A. (D)	17th, 19th, 24th assembly districts, Milwaukee	933 E. Ohio Ave., Milwaukee 53207
8.	—Busby, Allen J. (R)	20th, 21st, 22nd assembly districts, Milwaukee	1673 S. 53rd St., Milwaukee 53214
9.	* Parys, Ronald G. (D)	4th, 6th, 13th assembly districts, Milwaukee	1221 E. Clarke St., Milwaukee 53212
10.	—Knowles, Robert P. (R)	Buffalo, Pepin, Pierce, Burnett, Polk, St. Croix	New Richmond 54017
11.	* Whittow, Wayne F. (D)	8th, 10th, 16th assembly districts, Milwaukee	4921 W. Washington Blvd., Milwaukee 53208
12.	—Krueger, Clifford W. (R)	Clark, Forest, Oneida, Vilas, Lincoln, Taylor	122 N. State St., Merrill 54452
13.	* McKenna, Dale T. (D)	1st assembly district, Dodge; Jefferson, Washington	335 East North St., Jefferson 53549
14.	—Lorge, Gerald D. (R)	Outagamie, Waupaca	Bear Creek 54922
15.	* Swan, James D. (R)	1st, 3rd assembly districts, Rock; Walworth	R. 2, Elkhorn 53121
16.	—Thompson, Carl W. (D)	4th, 5th assembly districts, Dane; 2nd assembly district, Rock	R. 3, Stoughton 53589
17.	* Roseleip, Gordon W. (R)	Grant, Green, Iowa, Lafayette, Richland	Box 167, Darlington 53530
18.	—Hollander, Walter G. (R)	2nd assembly district, Dodge; Fond du Lac	R. 1, Rosendale 54974
19.	Steinhilber, Jack D. (R)	Winnebago	1748 Southland Ave., Oshkosh 54901
20.	—Keppler, Ernest C. (R)	Ozaukee, Sheboygan	909 New York Ave., Sheboygan 53081
21.	* Dorman, Henry (D)	1st, 2nd assembly districts, Racine	422 16th St., Racine 53403
22.	—Lourigan, Joseph (D)	Kenosha	3604 19th Ave., Kenosha 53140
23.	Peloquin, Bruce S. (D)	Barron, Chippewa, Dunn, Washburn	R. 5, Chippewa Falls 54729
24.	—Heinzen, Raymond F. (R)	Green Lake, Waushara, Portage, Wood	R. 5, Marshfield 54449
25.	* Cirilli, Arthur A. (R)	Ashland, Bayfield, Douglas, Iron, Price, Rusk, Sawyer	909 E. 4th St., Superior 54880
26.	—Risser, Fred A. (D)	1st, 2nd, 3rd assembly districts, Dane	5409 Esther Beach Rd., Madison 53713
27.	Bidwell, Everett V. (R)	Adams, Columbia, Juneau, Marquette, Sauk	612 W. Edgewater St., Portage 53901
28.	—Devitt, James C. (R)	23rd assembly district, Milwaukee; 3rd assembly district, Racine; 4th assembly district, Waukesha	5151 S. Root River Pkwy., Greenfield 53228
29.	* Chilsen, Walter John (R)	Marathon, Menominee, Shawano	R. 5, Box 25, Wausau 54401
30.	—LaFave, Reuben (R)	3rd assembly district, Brown; Florence, Marinette, Langlade, Oconto	R. 1, Box 89A, Oconto 54153
31.	* Johnson, Raymond C. (R)	Eau Claire, Jackson, Monroe, Trempealeau	221 N. 12th St., Eau Claire 54701
32.	—Knutson, Milo C. (R)	Crawford, Vernon, La Crosse	804 Cass St., La Crosse 54601
33.	Murphy, Roger P. (R)	1st, 2nd, 3rd assembly districts, Waukesha	1012 Hawthorne Circl Waukesha 53186

—Hold-over senators from 1969 legislature.

* Served in 1969 senate.

1971 Wisconsin Assembly

Members of the 1971 Wisconsin Assembly

District (Counties)	Name (Party)	Address
Adams, Juneau and Marquette	*Thompson, Tommy G. (R)	1407 Academy St., Elroy 53929
Ashland, Bayfield and Iron	*Korpela, Ernest J. (D)	633 E. 3rd St., Washburn 54891
Barron and Washburn	Schricker, Kenneth M. (R)	R. 2, Spooner 54801
Bayfield (See Ashland)		
Brown, 1st	*Quinn, Jerome (R)	137 N. Oakland Ave., Green Bay 54303
Brown, 2nd	*Kafka, Lawrence J. (R)	R. 3, Denmark 54208
Brown, 3rd	*Vanderperren, Cletus (D)	R. 5, Green Bay 54301
Buffalo, Pepin and Pierce	Early, Michael P. (D)	1052 S. Fork Dr., River Falls 54022
Burnett and Polk	*Dueholm, Harvey L. (D)	R. 2, Luck 54853
Calumet	*Hephner, Gervase A. (D)	618 S. Madison St., Chilton 53014
Chippewa	Willkom, Terry A. (D)	R. 4, Box 56, Chippewa Falls 54729
Clark	Oberle, Eugene W. (D)	R. 3, Stanley 54768
Columbia	Thompson, Robert M. (D)	R. 1, Poynette 53955
Crawford and Vernon	*Lewison, Bernard (R)	11 S. Washington Heights, Viroqua 54665
Dane, 1st	*Anderson, Norman C. (D)	5325 Marsh Rd., Madison 53704
Dane, 2nd	*Nager, Edward (D)	P. O. Box 2036, Madison 53705
Dane, 3rd	Miller, Mrs. Marjorie M. (D)	1937 Arlington Pl., Madison 53705
Dane, 4th	Everson, Harland E. (D)	R. 3, Box 750, Edgerton 53534
Dane, 5th	*O'Malley, David D. (D)	315 W. Main St., Waunakee 53597
Dodge, 1st	*Luckhardt, Mrs. Esther D. (R)	211 N. Hubbard St., Horicon 53032
Dodge, 2nd	Hanson, Thomas S. (D)	R. 1, Beaver Dam 53916
Door and Kewaunee	Swoboda, Lary J. (D)	507 Oak St., Luxemburg 54217
Douglas	*Stack, Edward (D)	1420 John Ave., Superior 54880
Dunn	*Baldus, Alvin (D)	111 12th St., Menomonie 54751
Eau Claire, 1st	*Looby, Joseph L. (D)	1156 E. Madison St., Eau Claire 54701
Eau Claire, 2nd	*Mato, Louis V. (D)	Fairchild 54741
Florence and Marinette	*LaFave, William G. (R)	R. 1, Peshtigo 54157
Fond du Lac, 1st	*McEssy, Earl F. (R)	361 Forest Ave., Fond du Lac 54935
Fond du Lac, 2nd	*Schwefel, William S. (R)	R. 1, Oakfield 53065
Forest, Oneida and Vilas	Gaulke, Ellsworth K. (D)	Lac du Flambeau 54538
Grant	*Azim, James N., Jr. (R)	Muscoda 53573
Green and Lafayette	*Tregoning, Joseph E. (R)	R. 2, Shullsburg 53586
Green Lake and Waushara	*Wilcox, Jon P. (R)	Box 157, Wautoma 54982
Iowa and Richland	Duren, Joanne M. (D)	Cazenovia 53924
Iron (See Ashland)		
Jackson and Trempealeau	*Radcliffe, John (D)	620 Elm St., Strum 54770
Jefferson	*Wackett, Byron F. (R)	100 Oak Hill Ct., Watertown 53094
Juneau (See Adams)		
Kenosha, 1st	*Molinaro, George (D)	424 44th St., Kenosha 53140
Kenosha, 2nd	Dorff, Eugene (D)	8045 19th Ave., Kenosha 53140
Kewaunee (See Door)		
La Crosse, 1st	*Greider, Gerald A. (R)	1729 Adams, La Crosse 54601
La Crosse, 2nd	Roberts, Virgil D. (D)	427 Lee St., Holmen 54636
Lafayette (See Green)		
Langlade and Oconto	*McDougal, Milton (R)	402 Chestnut Ave., Oconto Falls 54154
Lincoln and Taylor	*Sweda, Joseph (D)	Lublin 54447
Manitowoc, 1st	*Helgeson, Donald K. (R)	937 N. 5th St., Manitowoc 54220
Manitowoc, 2nd	*Bolle, Everett E. (D)	Forest Home Dr., Francis Creek 54214
Marathon, 1st	*Day, Laurence J. (D)	R. 1, Eland 54427
Marathon, 2nd	*Earl, Anthony S. (D)	917 Graves Ave., Wausau 54401
Marinette (See Florence)		
Marquette (See Adams)		
Menominee and Shawano	*Grover, Herbert Joseph (D)	R. 3, Shawano 54166
Milwaukee, 1st	*Lipscomb, Mark G., Jr., (D)	5349 N. Dexter Ave., Milwaukee 53209
Milwaukee, 2nd	*Jones, Joseph E. (D)	4285 N. 26th St., Milwaukee 53209
Milwaukee, 3rd	*Conta, Dennis (D)	3489 N. Hackett Ave., Milwaukee 53211
Milwaukee, 4th	*Sanasarian, Harout (D)	1111 N. Astor St., Milwaukee 53202
Milwaukee, 5th	*Sicula, Paul E. (D)	3287 N. 48th St., Milwaukee 53216
Milwaukee, 6th	*Barbee, Lloyd A. (D)	321 E. Meinecke Ave., Milwaukee 53212
Milwaukee, 7th	*Johnson, William A. (D)	3403 N. 22nd St., Milwaukee 53206
Milwaukee, 8th	*Czerwinski, Joseph C. (D)	1230 S. 34th St., Milwaukee 53215
Milwaukee, 9th	*Jackson, Robert L., Jr., (D)	7869 N. 57th St., Milwaukee 53223
Milwaukee, 10th	*Kessler, Frederick P. (D)	2719 W. Juneau Ave., Milwaukee 53208
Milwaukee, 11th	*Tobiasz, Raymond J. (D)	3145 S. 50th St., Milwaukee 53219
Milwaukee, 12th	*Orlich, Sam L. (D)	1307 W. Mineral St., Milwaukee 53204
Milwaukee, 13th	Bultman, Glenn E. (D)	2556 N. Weil St., Milwaukee 53212
Milwaukee, 14th	*Kleczka, Gerald D. (D)	3427 S. 9th Pl., Milwaukee 53215
Milwaukee, 15th	Wahner, James W. (D)	2932 N. 63rd St., Milwaukee 53210
Milwaukee, 16th	*Pabst, Richard E. (D)	457A S. 74th St., Milwaukee 53214
Milwaukee, 17th	*McCormick, John E. (D)	2954 S. Wentworth Ave., Milwaukee 53207
Milwaukee, 18th	Berger, David G. (D)	4443 N. 82nd St., Milwaukee 53218
Milwaukee, 19th	*Hanna, Daniel D. (D)	2501 W. Henry Ave., Milwaukee 53221
Milwaukee, 20th	*Klicka, George H. (R)	2115 N. 86th St., Wauwatosa 53226
Milwaukee, 21st	*Lynn, James J. (D)	1126 S. 94th St., West Allis 53214
Milwaukee, 22nd	*Huber, Robert T. (D)	2228 S. 78th St., West Allis 53219
Milwaukee, 23rd	Rutkowski, James A. (D)	10223 Kay Parkway, Hales Corners 53130
Milwaukee, 24th	*Atkinson, William P. (D)	1115 16th Ave., South Milwaukee 53172
Milwaukee, 25th	*Sensenbrenner, F. James, Jr. (R)	1601 E. Lake Bluff Blvd., Shorewood 53211
Monroe	Quackenbush, Robert L. (R)	510 Spring St., Sparta 54656
Oconto (See Langlade)		
Oneida (See Forest)		
Outagamie, 1st	*Froehlich, Harold V. (R)	421 W. Sixth St., Appleton 54911
Outagamie, 2nd	*Rogers, William (D)	1317 Hillcrest Dr., Kaukauna 54130
Outagamie, 3rd	*Conradt, Ervin (R)	R. 2, Shiocton 54170
Ozaukee	*Schowalter, Herbert J. (R)	642 S. Main St., Saukville 53080
Pepin (See Buffalo)		
Pierce (See Buffalo)		
Polk (See Burnett)		
Portage	*Groshek, Leonard A. (D)	2125 Indiana Ave., Stevens Point 54481
Price, Rusk & Sawyer	Slaby, John W. (D)	Box 22, Phillips 54555
Racine, 1st	Ferrall, Michael (D)	1816 Wisconsin Ave., Racine 53403
Racine, 2nd	*Brown, Manny S. (D)	2817 Ruby Ave., Racine 53402
Racine, 3rd	*Stalbaum, Merrill (R)	R. 1, Box 38, Waterford 53185
Richland (See Iowa)		
Rock, 1st	*Mittness, Lewis T. (D)	730 N. Ringold St., Janesville 53545
Rock, 2nd	Mielke, Mrs. Janet Soergel (D)	R. 1, Milton Junction 53564
Rock, 3rd	Johnson, Gary K. (D)	1818 Fayette, Beloit 53511
Rusk (See Price)		
St. Croix	Mohn, Leo O. (D)	Woodville 54028
Sauk	Geise, Kenyon E. (R)	R. 1, Loganville 53943
Sawyer (See Price)		
Shawano (See Menominee)		
Sheboygan, 1st	*Otte, Carl (D)	1440 S. 22nd St., Sheboygan 53081
Sheboygan, 2nd	*Boeckmann, Vernon R. (D)	R. 2, Plymouth 53073
Taylor (See Lincoln)		
Trempealeau (See Jackson)		
Vernon (See Crawford)		
Vilas (See Forest)		
Walworth	*Wilger, Clarence J. (R)	R. 4, Elkhorn 53121
Washburn (See Barron)		
Washington	*Schroeder, Frederick C. (R)	R. 1, Box 150, West Bend 53095
Waukesha, 1st	*Merkel, Kenneth J. (R)	3405 N. Brookfield Rd., Brookfield 53005
Waukesha, 2nd	*Alberts, John M. (R)	1228 W. Wisconsin Ave., Oconomowoc 53066
Waukesha, 3rd	Jackamonis, Edward G. (D)	151 S. Grand Ave., Waukesha 53186
Waukesha, 4th	*Shabaz, John C. (R)	21425 W. Glengarry Rd., New Berlin 53151
Waupaca	*Byers, Francis R. (R)	Garfield Ave., Marion 54950
Waushara (See Green Lake)		
Winnebago, 1st	Guiles, Jon R. (R)	2010 Wisconsin St., Oshkosh 54901
Winnebago, 2nd	*Bradley, Gordon R. (R)	2644 Elo Rd., Oshkosh 54901
Winnebago, 3rd	Ellis, Michael G. (R)	218 Clybourne St., Neenah 54956
Wood, 1st	Oestreicher, John C. (D)	911 S. Cherry Ave., Marshfield 54449
Wood, 2nd	Schneider, Marlin D. (D)	921 Washington St., Wisconsin Rapids 54494

*Served in 1969 assembly.

See following pages for maps showing assembly districts in counties which have more than one assembly district.

Consent and Related Forms for Physicians

PREFACE

FORMS WHICH A PHYSICIAN may have occasion to use in his regular everyday practice were printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL, and, therefore will not be reprinted here. Any physician wishing copies of these forms may obtain them upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; or tel. 608/257–6781.

Form numbers and titles as they appeared in 1970 are listed at the end of this article for easy reference when requesting such forms.

These forms will frequently need to be adapted for a particular situation. Each physician should read them carefully before using them to make sure that they reflect the realities of a specific situation.

The forms, as printed in 1970, and the text below have been prepared by legal counsel for the State Medical Society of Wisconsin, and reflect changes in the laws and courts in Wisconsin since the previous publication in the January 1958 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL.

The forms do not cover every possible situation where a consent should be obtained. Additional forms are contained in a publication of the American Medical Association called *Medico-legal Forms with Legal Analysis, 1961*. The Society attorneys suggest that any forms that a physician might wish to use outside of the forms contained in this article be checked with the physician's personal attorney to determine their legal adequacy.

Finally, the forms do not cover those procedures which are normally done in a hospital. The Wisconsin Hospital Association has published a text entitled *Consent Manual*. All member hospitals of that Association have the manual. Those forms cover hospital situations, whereas this article is concerned primarily with the physician in his regular practice.

I. What Is Consent

Consent, in the context that we are using it, means permission from a patient or his legal representative, to a physician to diagnose and treat the patient.

a. Informed Consent

To be legally valid, an informed consent can be given only after the patient, or his parent or guardian, has an understanding of what is to be done and the risks involved. You, the physician must tell the patient, or his legal representative, in terms that he can understand, what you believe is necessary in his case. Then, you must tell him the risks that he will be taking if he follows your advice. The extent of disclosure of the risks is a matter of sound professional judgment.

b. Implied Consent

There are situations where the consent of the patient does not have to be in writing or even expressed orally. This is implied consent.

A classic example of implied consent is the unconscious victim of an automobile accident where immediate action needs to be taken to save the life of the patient or at least to minimize the effect of his injuries. In this emergency situation consent is implied. The courts say that if the patient had been conscious he would have given consent to save his life and, therefore, the physician will not be penalized for doing what he would have been allowed to do if the patient had been conscious.

II. Who Can Consent

Persons who are adults and are competent to understand what the physician is proposing to do, why it is necessary or desirable, and what the risks of doing it are going to be, can give a consent.

REPRINTS OF CONSENT AND RELATED FORMS

The forms referred to in this article are not being reprinted here since they did appear in the January 1970 "Blue Book" issue. If the January 1970 issue is not available, reprints of these forms can be ordered from the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; tel. 608/257–6781.

a. Minors

In Wisconsin, persons under the age of 21 are minors.

The proper person to consent to surgery or other treatment of a minor is either parent, or if neither parent is living, the minor's court appointed guardian. A physician is not legally protected by a consent signed by a relative of a minor, other than a parent, unless the relative has been appointed as the minor's legal guardian by a court.

There are two exceptions to the above general rule. First, in an emergency, a consent is not necessary if the parents or guardian cannot be located, and, in the judgment of the physician in charge and, of consultants where consultation is practical, immediate treatment is necessary to save life or to prevent the deterioration or aggravation of the condition of the patient.

The legal reason for the above exception is that in an emergency the law implies the consent of the patient, or in the case of a minor, of his parent or guardian. Because the law does not imply consent beyond the treatment actually necessary to meet an emergency, the physician may safely treat only the emergency condition itself, and nothing else, without actual consent of a parent or guardian.

Second, an emancipated minor can give a consent for medical treatment, including surgery. A minor is emancipated (1) who is lawfully married, or (2) whose parents have divested themselves of their legal right of control over him. Typically a minor in the latter situation is one who is self-supporting. An unmarried minor attending school away from his home community is not emancipated by virtue of that fact alone.

A physician who has any doubt whether a minor is emancipated, should require the consent of a parent or the legal guardian before proceeding with non-emergency treatment.

b. Incompetents

Physicians, above all others, are qualified to determine whether a person is competent to sign a consent. If a person is incompetent a consent will not be any protection. For incompetents other than minors, consent can only be given by the person's legally appointed guardian, except in emergencies.

c. Persons under the influence of drugs or intoxicants

Unless there is an emergency situation, the physician should either wait until the influence of the drug or intoxicant passes, or, make appropriate contacts for the appointment of a guardian. In the case of an emergency, treatment necessary to save life can be given.

III. Why Consents

A physician who operates on a patient without authority commits an assault and battery on the patient. He may have to pay money damages to the patient, or he may even be subject to criminal fines and imprisonment.

Written consents, or oral consents given before witnesses, preferably non-involved, are the best proof that a physician can have to show that what he did was duly authorized by a patient.

A few minutes spent preparing, explaining and having the consent signed can save untold hours of time, money and embarrassment for the physician.

IV. Consents Limited

A word of caution needs to be set forth. A valid consent must not be too broad. It cannot be a general consent for the physician to do anything he wants to do. It should be limited to the specific situation presented by the diagnosis of the patient's illness. Finally, a consent is not effective if the treatment or procedure consented to is illegal, is contrary to public policy or, is given by a person who had no legal right to give it.

V. Consent and Related Forms

The text and suggestions that follow are related to the numbered forms that appeared in the January 1970 "Blue Book" issue. The form numbers and titles appear at the end of this article. Physicians should read the text and suggestions prior to attempting to use or adapt a particular form.

PHYSICIAN AND PATIENT

1. Contract for Services

The physician–patient contract is established when the physician, in response to an express or implied request to treat the patient, undertakes to render professional services to him. It is not necessary to have a formal written contract. The contract between the patient and physician is implied and is enforceable. If you wish, you may restrict your services to one procedure, one treatment or treatments at a particular time or place. This can be done by a letter requesting the patient to sign and return a copy to you. No form has been included for this situation. A physician need not accept every person who wishes services. He can accept patients as he wishes. Further, specialists need not accept patients who have illnesses outside their specialty.

However, once the patient–physician relationship has been entered into the physician is under

an obligation to treat the patient until the relationship is terminated.

2. Termination of Contract

Care must be taken to inform the patient appropriately, but unmistakably when the patient–physician relationship is terminated. What should be done depends upon how the situation arises.

a. Former Patient

If you have a former patient who calls and wishes further services, and you do not wish to further treat that patient, you should make your decision clear. Following such conversation you should confirm it by a letter. Form 1, with its enclosure, Form 2, is appropriate and gives the physician a record for his file.

b. Withdrawal from a Case

There may be occasions where a physician does not wish to continue on a case. Consistent with legal as well as ethical principles he must find appropriate steps to withdraw. He cannot just stay away and not notify the patient. This would be abandoning the patient and could subject the physician to a suit for damages.

He must give the patient proper notice that he is withdrawing from the case and must give the patient a reasonable amount of time to obtain a new physician. What is a reasonable amount of time will depend upon the circumstances of the case and the availability of other physicians in the area. We suggest that under most circumstances that the time set forth be not less than five (5) days. To provide a record and protect the physician a letter should be sent to the patient. If the letter is sent by certified mail with a return receipt requested, the physician will have record in his file showing not only that the patient was notified, but also the date the patient received the notification. Form 3 is appropriate for this purpose. We suggest that you may wish to enclose Form 2 with the letter for the patient's convenience.

c. Discharge of a Physician

The patient may also terminate the contract by discharging the physician. The physician will want to make an immediate and adequate record that he did not abandon the patient. The physician may do well to try to obtain from the patient a signed statement of the facts and discharge of the physician. Where this is not available we suggest that the physician send a letter to the patient such as Form 4. Again, the enclosure of Form 2 is appropriate. We suggest the letter be sent by certified mail, with a return receipt requested so that your file will show receipt of the letter by the patient.

3. Special Problems During Treatment

There are many problems that can arise during the treatment of a patient. The ones covered in this section are of particular importance to the physician since, if no protective steps are taken and a record made of such steps, the defense against allegations of malpractice could be made considerably harder and more expensive.

a. Patient Who Fails to Follow Advice

Where a physician feels that a certain treatment or procedure should be done and the patient refuses, a record should be made. Form 5 may be adapted to the situation as it occurs.

b. Patient Who Fails to Keep Appointment

If a patient fails to keep an appointment where the patient has a condition the physician knows needs treatment, the physician should make this fact known to the patient. The physician, at the same time, should see that his records reflect his professional advice to the patient. A letter such as Form 6 should be sent to the patient.

c. Patient Who Leaves Hospital Against Medical Advice

Cases arise where patients refuse to remain in a hospital even though their physician feels that continued hospitalization is necessary. Form 7 provides a statement that the patient may sign which will release liability for the patient's acts. The physician should have two witnesses with him at the time he informs the patient of the reasons the physician feels indicate the need for continued hospitalization. These witnesses should sign the form whether the patient signs the form or not. If the patient refuses to sign, that fact should be noted on the form. The physician should have a copy of the form for his office records. The hospital will also want a copy for their records.

d. Substitute Physician in Obstetrical Cases

It is not unusual for a physician to be unable to be present at a delivery, even though the physician would wish to be there. Another delivery might be in progress or the speed of delivery might make it impossible for the physician to get to the place of delivery. The physician should explain this to his obstetrical patient when she first comes to his office. The physician should have the expectant mother sign a form such as Form 8 as an acknowledgment of the fact that she understands and agrees.

e. Office Treatment

Some procedures can be done either in the physician's office or in the hospital. Where the physician decides to do the procedure in his office he should inform the patient of the alternatives and any special risks involved. If the patient decides

that the procedure should be done in the hospital, the physician should not attempt to do the procedure in his office. If the patient does agree to having the procedure in the office, then the physician should have the patient sign a consent such as Form 9.

4. Confidential and Privileged Relationship

In Wisconsin, communications between a patient and his physician are protected both by law and ethics.

Under Wisconsin law, certain disclosures made by a patient to his physician in order to give the physician sufficient information to enable him to treat the patient are "privileged." This "privilege" means that the statements cannot be disclosed by the physician unless the patient allows it or unless the physician is allowed or required by law to disclose them. The "privilege" is that of the patient, and can ordinarily be claimed or released only by the patient.

Confidential communications involve a physician's ethical duty to keep secret the information he has obtained about a patient while acting in his professional capacity. This obligation is independent of the privilege discussed in the preceding paragraph. It is binding on the physician at all times.

Unauthorized disclosure of confidential information can be grounds for revocation of the physician's license. It may also be the basis for a suit for damages by the patient. Each physician therefore must exercise care to protect against unauthorized disclosure of confidential or privileged information.

a. Release of Medical Information

The State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly prepared an interpretation of the Wisconsin law concerned with examination of medical records. Any physician may request a copy from the State Medical Society. Its title is: *"An Interpretation of Chapter 301; Laws of 1959."* It has also been printed in the January 1968 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL beginning on page 45. The consent form set forth in that Interpretation is represented in the January 1970 "Blue Book" issue as Form 10.

b. Photographs

Physicians may wish to make a visual record of a case for several reasons. In cosmetic surgery it may show the result of the surgery. In other cases it may show the result of a particular method of treatment. It may also be used for unusual cases where documentation would be valuable for teaching purposes. In any of these cases there must be a release of the confidential or privileged relationship to allow the taking of photographs. Forms 11 and 12 may be used for this purpose.

c. Observers, Motion Pictures, Television

In cases similar to those where photographs may be desirable, there are cases which should be observed, televised or recorded on film. The release of the confidential or privileged relationship must also be obtained in these cases. Forms 13, 14 and 15 may be used for these situations.

VI. Special Situations

There are certain procedures which the physician should approach with caution and be sure to take the necessary steps to document what has happened and, to be sure that he proceeds only with proper authority.

1. Abortions

There are two types of abortion cases that are presented to physicians. Under Wisconsin law certain things need to be done, but they vary depending on the type of case.

a. Therapeutic Abortion

Wisconsin law recognizes the necessity for therapeutic abortions, but allows such an abortion only when three specific conditions have been met, namely:

1. The abortion must be performed by a physician.
2. At least two other physicians must advise that the abortion is, or appears to be, necessary to save the life of the mother. Therapeutic necessity must be based on danger to the mother's life, not simply on danger to her health. In an emergency the physician is permitted by statute to perform an abortion without the advice of two physicians, but he must be able to prove that the abortion was necessary to save the life of the mother.
3. The abortion must be performed in a licensed maternity hospital, except where emergency prevents.

Form 16 should be signed by the three physicians in order to have a written record to meet the condition of Wisconsin law.

b. Recent or Partial Abortion

If a woman comes to you and asks you to treat an attempted or completed abortion, you should take reasonable precautions before treatment. The Wisconsin Supreme Court has stated that the following steps are proper for a physician to take:

1. insist on the presence of at least one other physician (not an associate) before treatment is given, or

2. when no other physician is available, insist on a written statement from the patient, in the presence of witnesses, if possible, reciting the facts concerning the performance of the abortion and including the name of the abortionist. The necessary treatment should then be given only after the patient understands that the physician may use the statement in the event he later requires it for his own protection.

Form 17 can be used as a model for a statement by the patient.

2. Artificial Insemination

There are two types of artificial insemination. First where the husband's semen is used and, second, where the semen of a male other than the husband is used.

a. Artificial Insemination—Homologous

AIH involves the use of the husband's semen to attempt to make the wife pregnant. A consent should be signed by both the husband and the wife. Form 18 can be used for this purpose. It is believed there is no legal complication for this situation.

b. Artificial Insemination—Donor

AID involves the use of the semen of a male other than the husband. In such case there are persons other than the husband and wife to consider, namely, the donor, and if he be married, his wife.

The husband and wife must consent. Form 19 provides for this.

In this situation we also recommend that the donor and his wife execute consents such as Forms 20 and 21.

There is a diversity of opinion on the legality and morality of this type of artificial insemination. It is recommended that prior to the use of these forms each physician consult his personal attorney.

3. Sterilization

In Wisconsin, neither therapeutic nor non-therapeutic sterilization is a crime according to a 1968 opinion of the State Attorney General. Sterilization can result from three separate situations.

a. Sterilization As a Result of An Operation for Other Purposes

Some cases can result in sterilization, although the purpose of the operation is not to achieve sterilization. This risk must be explained to the patient in terms that he can understand. Then the physician should have the patient sign a separate consent form for this express purpose. Form 22 can be used for this purpose. The spouse should be urged to sign the consent. This is to avoid later statements by the spouse that he or she knew nothing about the possibility of sterilization.

b. Therapeutic Sterilization

Medical reasons exist for operations which are intended to sterilize the patient. In such cases a consent should be obtained from both the husband and the wife. Form 23 can be used for this procedure.

c. Non-Therapeutic Sterilization

Requests for non-therapeutic sterilization should be the subject of a conference with both the husband and the wife. The nature of the operation, the fact that it cannot be guaranteed as 100% effective, should all be explained in detail. Then, if they wish to proceed, a consent such as Form 24 should be signed.

VII. Other Consent Forms

Other forms not mentioned above, but which may be of common use to a physician, have been included in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL. These forms are believed not to require explanatory text. Before they are signed, the physician should review the requirements for a valid consent given earlier in this article.

Form Numbers and Titles

The following form numbers and titles refer to the forms as printed in the January 1970 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL and are listed here as an aid to ordering the forms from the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701; tel. 608/257-6781.

Form 1: Letter to former patient where physician does not wish to treat later illness.
Form 2: Authorization to disclose information to new physician.
Form 3: Letter of withdrawal from case.
Form 4: Letter to confirm discharge by patient.
Form 5: Letter to patient who fails to follow advice.
Form 6: Letter to patient who fails to keep appointment.
Form 7: Statement of patient leaving hospital against medical advice.
Form 8: Provision for substitute physician at delivery.
Form 9: Consent to office treatment.
Form 10: Consent to examination of physician's records.
Form 11: Consent to taking of photographs.
Form 12: Consent to publication of photographs.
Form 13: Authority to admit observers.
Form 14: Consent to taking of motion pictures of operation.
Form 15: Consent to televising of operation.
Form 16: Statement of need for therapeutic abortion.
Form 17: Authorization to treat condition of recent or partial abortion.
Form 18: Artificial insemination homologous consent.

Form 19: Aid consent.
Form 20: Aid donor consent.
Form 21: Aid donor's wife consent.
Form 22: Consent to sterilization as a result of operation.
Form 23: Consent to therapeutic sterilization.
Form 24: Consent to non-therapeutic sterilization.
Form 25: General consent to operation.
Form 26: Consent to operation.
Form 27: Consent to operation for cosmetic purposes.
Form 28: Consent to removal of tissue for grafting.
Form 29: Consent to operation and grafting of tissue.
Form 30: Order for taking of x-ray films.
Form 31: Consent to x-ray therapy.
Form 32: Permission to use radioisotopes.
Form 33: Consent to diagnostic procedure.
Form 34: Agreement for blood transfusion.
Form 35: Agreement for blood plasma transfusion.
Form 36: Agreement with blood donor.
Form 37: Release and receipt (blood donor).
Form 38: Agreement with blood donor.
Form 39: Release and receipt (blood donor).
Form 40: Consent to disposal of amputated part of organ.
Form 41: Gift of part of body under Wisconsin Uniform Anatomical Gift Act of 1969.
Form 42: Authorization for tissue donation.
Form 43: Authorization for autopsy and tissue donation.
Form 44: Authorization for autopsy.
Form 45: Consent to disposal of dead fetus.

RECOMMENDED MINIMUM EMPLOYMENT STANDARDS FOR REGISTERED PROFESSIONAL NURSES IN WISCONSIN—Adopted and Approved October, 1970

Copies of this booklet are available upon request from the Wisconsin Nurses Association, Inc., 161 West Wisconsin Avenue, Milwaukee, Wis. 53203; or tel. (area code 414) 272-3670.

CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) EDUCATIONAL BENEFITS

A letter dated November 10, 1970, from the Office for Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) outlined CHAMPUS educational benefits as follows:

1. CHAMPUS will pay for education service, regular, special, and/or vocational, under the following conditions:

a. HANDICAP PROGRAM

Inpatient or Outpatient: CHAMPUS will pay for all educational services necessary to treat or correct the handicapping condition or to alleviate, overcome, or adjust to deficiencies resulting from the handicapping condition. Normally CHAMPUS will not pay for educational services in lieu of suitable and available public school services, nor provide for regular education services past the high school level. Special education services are authorized for preschool age children.

b. BASIC PROGRAM

(1) *Inpatient:* Education services are an essential part of effective treatment program for children in CHAMPUS approved inpatient institutions undergoing therapy for chronic conditions or diseases, and/or for nervous, mental, or emotional disorders. CHAMPUS will pay for these services.

(2) *Outpatient:* CHAMPUS will also pay for remedial educational services on an outpatient basis when necessary to treat chronic conditions or diseases, and/or nervous, mental or emotional disorders in children when ordered by the attending physician. The physician must be a doctor of medicine or a doctor of osteopathy, preferably a child psychiatrist.

2. Special tutoring or education for "poorer students" is not a CHAMPUS benefit when the poor learning condition is not the result of a medical diagnosis.

3. TEACHER QUALIFICATIONS

a. Teachers should be certified or licensed as such in their respective states. In addition, they should possess the additional prerequisites required by state or local authority to qualify as remedial teachers or to provide the other special teaching skills needed by these CHAMPUS beneficiaries and for which payment is claimed. If the jurisdiction in which provider is located does not require specific licensure, teachers, or therapists must be eligible in membership in the state or national association setting the standards for their respective groups.

b. Because the importance of reading skills, in states that do not have certification requirements for reading specialists, these providers, as a minimum, must be certified as teachers in their states and have satisfactorily completed the following requirements towards a Master's Degree established by the International Reading Association, Newark, Delaware:

(1) A course in the diagnosis and correction of reading disabilities.

(2) A course involving a clinical or laboratory practicum in the teaching of reading.

(3) The courses in (1) and (2), above, may be waived providing the teacher has past experience as a reading specialist and the attending physician certifies that the services to be provided by the reading specialist meet the requirements of the treatment of the patient.

WPS Blue Shield, the insurance plan of the State Medical Society of Wisconsin, administers the CHAMPUS program in Wisconsin.

Physician and Hospital Records Retention and Inspection

IT IS AGREED that ownership of medical and hospital records rests, respectively, with the physician and the hospital. The doctor-patient-hospital relationship has been considered by the legislature and the courts. They have declared it to be in the public interest that the patient have access to relevant records concerning his medical care and treatment.

Because physicians, hospital personnel, patients and others are not always clear as to their respective rights and obligations, and because there is uncertainty as to what constitutes a "medical record" or "hospital record", representatives of the State Medical Society of Wisconsin and the Wisconsin Hospital Association have jointly undertaken an *Interpretation* on this subject which was printed in full beginning with page 45 of the January 1968 "Blue Book" issue of the WISCONSIN MEDICAL JOURNAL. If this issue is not available, copies may be obtained upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701, or telephone 608/257-6781.

The *Interpretation* was approved by the Council of the State Medical Society and the Board of Trustees of the Wisconsin Hospital Association. It contains recommendations and suggestions regarding hospitals' and physicians' responsibilities under Section 269.57 (4).

Patient and hospital records today include not only the written history, diagnosis, treatment, prognosis and related summaries, but such additional items as: x-rays, laboratory reports and correspondence with other physicians relative to a particular patient and to a particular condition.

Since a patient does have a general right to inspect his medical and hospital records, the question how long to retain records is automatically raised.

For purposes of this article patients can be classified into three legal categories. Each category calls for retention of records for different periods. These are patients (1) over 21 who are mentally competent; (2) over 21 who are mentally ill; and (3) under 21.

Among others, the following reasons for retention of patient records, whether in original or reproduced form, must be considered:

1. To aid medical science; also to facilitate the care of a particular patient who requires treatment or hospitalization at a later time.
2. To provide a record for the assistance of the patient in enforcing his claim for injuries against others than the physician, hospital, or members of their respective staffs.
3. To assist the physician, hospital, a member of the medical or nursing staff, or other personnel in defending against an allegation of negligence made by or on behalf of the patient.
4. To assist the physician or hospital in collecting an unpaid debt due from a patient.

Recommendations

The following recommendations apply to each of the foregoing reasons for retention of records above noted.

1. As to the length of time for retaining records as an aid to medical science or to the patient himself, this will depend in part upon the facilities of the physician's office or the size and character of the hospital and will necessarily involve the judgment of the particular physician or of the medical staff of the hospital. In any event this is a matter of medical judgment and not of legal considerations.
2. A patient of legal age has *3* years within which to sue *for personal injuries*. If a patient elects to sue on *a contract* rather than for alleged *negligence*, he has *6* years in which to do so. In rare instances which would almost never apply to a patient-physician relationship, he might have up to 20 years. Such unusual situations would ordinarily be known to the physician's attorney. To aid the patient in enforcing his claims against others, it is recommended that records be retained for at least 6 years. We are unaware of any *legal* requirement for accommodating a former patient longer than the suggested 6 years, although there may be sound reasons for retaining them longer. No statute of limitation runs where fraud can be established.
3. The period recommended for retention of patient records to defend against an allegation of negligence would depend upon the category into which the patient falls. The principal categories can be summarized as follows:
   A. If the patient is over 21 and mentally competent, the Wisconsin Statutes require that he start an action for alleged negligence within 3 years after the alleged act.
   B. If the patient is over 21 and mentally ill at the time of his treatment or hospitalization,

or becomes so within 3 years thereafter, suit must be brought on his behalf, or by him if he recovers, within a maximum of 8 years.

C. If the patient is a sane minor at the time of the treatment or hospitalization, he must sue for the alleged negligence by the time he reaches 22, unless his guardian did so before he became of age.

4. To the extent that patients' records are retained to assist in collection of accounts, such claims must be enforced by the physician or hospital within 6 years of the time it was incurred, unless such time was extended by act of the person owing the account.

An accurate and durable reproduction of the record on microfilm or similar process is as fully admissible before a court as the original itself. *Therefore, the originals of your records, once they are microfilmed, may be destroyed. However, it is advisable to keep the original record for at least 3 years or until the patient has paid your bill.* The reasons for this recommendation are:

1. The original is in many ways more convenient to handle and to read than microfilm;
2. The opportunity for physical examination of an original patient record minimizes the chance of suspicion or an assertion that something is missing.

If you receive a request for examination and copying of records, it may not state what specific records are needed. Your records for that patient may go back for 20 years or more.

Before complying with the request of a patient to examine and copy his records, it is suggested that the physician confer, if practical, with the patient or his representative to ascertain *why* he needs his records copied for such a long period of time. If by any chance the records contain material relating to conditions which would be embarrassing to him, or which might involve other members of his immediate family, he might be very grateful to have the physician point this out and delete them from any preparation.

If practical, the physician might also ascertain who suggested the copying of records for such a long period. It could be important whether this was another physician, an insurance company, an employer, or an attorney for any of such parties.

Once the decision has been made how far back to go and just what portions of the total medical record are to be copied, the physician or hospital should *not* let the record leave the premises. For the information of physicians, the statute does *not* authorize the removal of medical or hospital records from the premises. Further, the physician or hospital should *not* permit *anyone* outside the staff to copy the record except in the presence of a staff member. Whether by intention or not, the physician or hospital might lose a portion of the record if they do not observe these precautions, and such loss could prove a serious handicap later.

Some physicians are requesting not only that the time periods to be copied from a medical record be specified but also that each particular illness be specified in the authorization from the patient.

A number of other precautions are indicated in the *Interpretation* of Chapter 301, Laws of 1959. The physician or anyone designated to handle this matter would do well to review the contents of the *Interpretation before* interviewing the patient or preparing such parts of the medical record as the physician concludes to furnish.

Needless to say, the physician should not proceed under any circumstances without a *written* authorization signed by the patient; and the physician should be satisfied that: (1) the signature is the patient's, (2) he is mentally competent to make the request, and (3) the information is not of the character which would be likely to cause him nervous or other damage. While it is true the patient has what looks like a rather direct and simple legal right, the fact also remains, as to any specific care and treatment furnished by the physician, that the latter has a continuing responsibility toward him for such care and treatment.

The 1963 Legislature authorized the personal representative or the beneficiary of a life insurance policy to sign an authorization in case of a patient's death. If you receive such an authorization you can ask the personal representative to provide you with a certified copy of his authority to act. This will take the form of "Letters Testamentary" or "Letters of Administration" which are issued by the County Court, Probate Branch. In the case of the beneficiary of life insurance, you can ask for a certified statement from the insurance company that (1) a policy on the patient was in force at the time of his death, and (2) that the person signing the authorization is the beneficiary under the policy. The duty to provide the physician is on the person seeking the information and the physician has no duty to release such information until he is satisfied that the person asking is so authorized.

Since no wording appears in the statutes prescribing the form of authorization to inspect and copy a patient's record, model forms are not recommended. Sample forms were included in "An Interpretation of Chapter 301; Laws of 1959" which appeared in the 1968 January Blue Book issue at page 45, but they should not be construed as more than suggested guides designed primarily to make clear the illness and period for which inspection and copying are sought.

AMA Ethics

The AMA has sent the following release to the State Medical Society. It is quoted in full for your information:

> "Is it ethical for a physician, retiring from practice, to sell his patients' records to another physician?

"According to an opinion adopted by the AMA Judicial Council in November, 1967, a physician's records have been developed during the physician-patient relationship. This relationship, referred to in Section 9 of the *Principles of Medical Ethics*, requires that a physician not reveal the confidences entrusted to him in the course of medical attendance. Therefore, since the physician's records summarize these confidences, they too are cloaked with this same protection.

"The Council states further that a transfer of a patient's records, without his consent, would violate this confidence. However, with the patient's consent, his records may be transferred to a physician of his choice and a reasonable charge made for secretarial or duplicating services.

"Furthermore, the judicial Council declares that a physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician." (AMA News Release No. 13, February 1968)

TAX DEDUCTIBILITY OF HEALTH AND ACCIDENT INSURANCE

One-half of medical care insurance premiums up to a maximum of $150.00 are fully deductible. Additional medical care premiums may be included with other medical expenses and are subject to the limited deduction of the excess of medical expenses over 3% of adjusted gross income.

Premiums paid for health and accident policies which provide indemnity for accidental loss of life, limb, sight or time, are deductible medical expenses only to the extent allocable to medical care and *only* if the charge for medical care is separately stated in the policy or in a statement sent to the policyholder by the insurance company. In addition, the charge for medical care on a combination policy is eligible for a medical expense deduction only if not unreasonably large in relation to the total premium under the contract.

All taxpayers, whatever their age, are subject to the same general rules. The same rules as are set out above also apply for 1970 Wisconsin income tax purposes.

Control of LSD

The Wisconsin Legislature has added LSD and other hallucinogens to the list of "dangerous drugs."

Specifically, Lysergic Acid, LSD (lysergic acid diethylamide), DMT (N-N-Dimethyltryptamine), peyote, mescaline, psilocyn or psilocybin, or any salts, derivatives, compounds, combinations or mixtures thereof and any substances which are chemically identical with such substances have been added to the list of dangerous drugs which may be used by or distributed to the general public only when prescribed by a licensed physician or other person authorized by law to prescribe or distribute such drugs.

In addition to expanding the list of drugs, the Legislature has broadened the penalties for violations of the dangerous drug law. Illegal use of dangerous drugs or possession without intent to sell such drugs is punishable by not more than one year imprisonment or $500 fine or both for the first offense. Penalties for a second or any subsequent offense are imprisonment of not more than two years and a fine of not less than $250 or more than $1,000 or both.

More severe penalties have been created for certain classes of violators. Thus, a "supplier" who is convicted of illegal possession, sale, furnishing or transportation of any dangerous drug may be imprisoned not more than five years or fined not more than $5,000 or both. A supplier is defined by the statute as any unauthorized person who manufactures, sells or gives any dangerous drug defined under this section for the use of any person for whom such drug has not been prescribed by a practitioner or who in any way delivers such contraband material to anyone he intends to induce to become a user.

In addition, punishment of not more than five years in prison or not more than $2,500 fine or both has been created for any person who intentionally advises, induces or encourages, directly or by any other means, another to commit a violation of the dangerous drug law.

The burden of proving that one should not be prosecuted under the "dangerous drug law" because of an exception, excuse, proviso or exemption contained in the law has been placed on the defendant. This means that if arrested and tried for a violation of the dangerous drug law, a physician or pharmacist who dispenses such drug would be required to prove that he fits within an exception.

Reference: Section 450.07, Wisconsin Statutes.

Workmen's Compensation and the Physician

VIRTUALLY every physician practicing in Wisconsin becomes involved with treatment of a patient covered by Workmen's Compensation. This law provides payment of compensation for disability and expense for medical attention necessary because of injury sustained in the course of and arising out of employment.

Please contact either the State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701, or Ralph E. Gintz, Administrator of the Workmen's Compensation Division, Hill Farms State Office Building, Box 2209, Madison, Wis. 53701, if you have any questions.

RECENT WORKMEN'S COMPENSATION RULES

Effective Jan. 1, 1969, a physician or any other employer except a farmer is subject to the Workmen's Compensation Act if (1) he usually employs three or more employes or (2) he pays wages of $500 or more in any calendar quarter subsequent to July 1, 1968, covering services within Wisconsin.

An employer subject to the Act must have Workmen's Compensation insurance coverage, which can be obtained from any insurance company authorized to do such business within Wisconsin.

Serious penalties exist for failure to have insurance coverage. First, such failure is a misdemeanor and subject to fine of from $10 to $100 for each day of such illegal operation.

Second, the employer is personally responsible if one of the employes is injured while he is subject to coverage and is uninsured. Negligence by the employe is not a defense, and it need not be shown that the injury was caused by negligence of the employer.

A physician paying such wages need only obtain an insurance policy for Workmen's Compensation to comply with the law. The state Workmen's Compensation office is automatically notified of the issuance of the policy.

Five points of advice will aid every physician in dealing with Workmen's Comp.:

★ Have your name listed on the State Medical Society's Workmen's Compensation panels if you want to treat employes under Workmen's Compensation.

★ Learn how to estimate disability according to the standards set up by the Department of Industry, Labor, and Human Relations (formerly the Industrial Commission). Other standards or schedules are fine for your own information, but only the Department's standards are authoritative in Wisconsin.

★ Submit your reports promptly. Delay may mean withholding of compensation to the injured employe and professional fees to the physician. Quite often the unexpected misfortune places the employe in urgent need of compensation.

★ Fill out the report forms carefully, completely. Learn the terminology of the statutes concerning compensable employment disability.

★ Don't be afraid to ask questions. Contact either the State Medical Society or Ralph E. Gintz at the addresses noted above.

"Open Panel" Listing

The State Medical Society of Wisconsin revises the "Open Panel" listings periodically (generally on a three-year basis). Revision was completed last fall (November 1970) with every member of the State Medical Society receiving a letter of explanation, the Workmen's Compensation Open Panel Agreement, and a return envelope. A reply to this communication MUST be made by every Society member. Although a member may not wish to participate, he still MUST reply indicating his preference.

Insurance companies licensed to sell W.C. insurance in Wisconsin also will be contacted (as in the past) regarding participation in the plan.

"Open Panel" listings distributed in October–November 1970 reached over 60,000 employers in Wisconsin.

PHYSICIANS EXEMPT FROM JURY DUTY

You don't have to serve as a juror unless you want to. All practicing physicians, surgeons, and dentists are exempt. This doesn't mean that you are disqualified from jury duty. The exemption is a personal privilege which you may claim or waive as you wish.

If you are called to act as a juryman and wish to take advantage of your exemption, appear in court when called and state the cause of your exemption to the presiding judge.

Reference: Section 255.02 (1) (b), Wisconsin Statutes.

Ethical Practices in Reference to Workmen's Compensation and the "Open Panel Program"

(PREPARED BY CONFERENCE COMMITTEE ON OPEN PANELS)

THE State Medical Society and the Workmen's Compensation insurance carriers have for many years subscribed to the principles of the Open Panel, wherein any member of the State Medical Society who so expresses a desire may have his name, office address, and office telephone listed on panels prepared on a county basis and distributed to employers covered by the Workmen's Compensation Act.

Being listed carries certain obligations upon the physician and the insurance carrier. The industrial nurse also has obligations and ethics which must guide her in her handling of the case.

To clarify certain points of possible misunderstanding, the Conference Committee on Open Panels is listing below certain principles which should be followed by all parties concerned with the medical aspects of the compensation program.

* * *

Consultation

It is a basic principle of the Open Panel Program that consultation can be requested by either the attending physician, the insurance carrier, the employer, or the employee. It is essential that the request for consultation be known to the other parties immediately concerned. Also, the selection of the consultant should be **mutually acceptable to both the attending physician, and the insurance carrier or the employer.**

If the Attending Physician Seeks Consultation: The insurance carrier should be notified of such a request, and if the consultant requested is not acceptable to the insurance carrier, another consultant acceptable to both parties should be selected. Under no circumstances should the attending physician arrange consultation without proper notification and authorization unless an emergency exists.

If the Insurance Carrier Seeks Consultation: Proper notification should be given the attending physician, and preferably he should be given the names of alternate consultants from which he can select one agreeable to him. Under no circumstances is it ethical for the insurance carrier (or the employer) to call in a consultant until agreement is made with the attending physician. If the attending physician refuses consultation, it is proper for the insurance carrier to place the matter in the form of a grievance before the Conference Committee on Open Panels; and if cooperation is still denied, the physician refusing consultation can be removed from the panel.

Frequency of Consultation: If the attending physician requests consultation, it can be as frequent as the insurance carrier deems reasonable. If the insurance carrier requests consultation, it can be as frequent as desired, and the insurance carrier is responsible for the reasonable expense of such consultation.

Filing of Consultation Reports: Under any circumstances the consultant is duty bound to file identical reports with both the attending physician and the insurance carrier of the employer.

Consultation Does Not Mean "Taking Over The Case": A consultant is not to take over the care of the case, except by mutual understanding and agreement. The case remains that of the attending physician until discharged by him, unless voluntarily released to the consultant. A written release is recommended. See page 8 of the January 1970 "Blue Book" issue of the *Wisconsin Medical Journal*, for recommended release form.

Reports

The filing of reports is a direct responsibility of any physician participating in the Workmen's Compensation Program. As a means of lessening the extent of paper work involved in required reporting the Conference Committee on Open Panels has devised simplified report forms for the initial report, the progress report, and the final report. The majority of insurance carriers subscribing to the Open Panel are using these forms. If physicians are requested to fill out complicated report forms, the Conference Committee will try to have the insurance company requesting such information adopt the simplified forms.

The Department of Industry, Labor, and Human Relations (formerly the Industrial Commission) WC–16 Report: This report form is to be completed by the physician participating in the compensation program when disability exceeds three weeks, or any permanent disability results

from the injury. The report form may be obtained from the insurance carrier or the Department of Industry, Labor and Human Relations, which uses the information thereon to determine the amount of compensation payable to the injured worker. Failure to supply the report promptly may mean that compensation will be withheld by the employer or insurance carrier, with injustice to the patient. It has been stated that compensation delayed may be as serious as compensation denied. The report form is filed with the employer or insurance carrier and transmitted by it to the Workmen's Compensation Division.

Payment for Reports: Occasionally physicians have suggested the advisability of being reimbursed for the preparation of reports for insurance companies and the Department. It is the opinion of the Conference Committee on Open Panels that the following principles be applied:

Simplified Reports (First Report, Progress Report, Final Reports): No charge.

WC–16 Report to the Department of I.L., and H.R.: No charge.

If special reports are requested, or the insurance carrier does not wish to use the recommended simplified reports and requires a rather extraordinary report, a separate charge (depending on the extent of the report) is proper.

Complaints

The Conference Committee on Open Panels was established to iron out any difficulties between participating physicians and insurance carriers in all matters concerning charges, alleged unethical practices, etc. However, the Conference Committee will not accept a case until efforts have been made, through local personal contact, to reach a satisfactory solution of the problem involved.

Free Choice of Physician

It is improper for an industrial nurse, or any person responsible to management, to direct an injured employee to a specific physician for care. If the injured patient asks for recommendations, a list of at least three physicians should be given, and the choice should be left entirely to the patient. When the Open Panel is used, every effort should be made to retain the relationship between injured worker and his family physician. If his injury is of a specialized nature which suggests need for consultation, such arrangements can be made as suggested above. If the injury involves the eye and a selection of physicians restricting their practice to this field is available, such information should be given the patient by referring him to the panel listing under the heading of "Eye, Ear, Nose and Throat." The industrial nurse must do her utmost to retain the good will of all physicians whose patients are employed in the plant. To do this she must bend every effort to maintain the philosophy of "free choice" of medical care for the injured employee.

Changing Physicians

The Compensation Act provides not only that the employee shall have the right to make choice of an attending physician from a panel but that he shall, if he wishes, have the right to make a second choice of physician from the panel upon request. If that is done there should be no hesitancy on the part of the first physician chosen to relinquish the right to treat, but also there should be full cooperation with the second physician chosen in order to afford him full access to history and treatment already rendered, so that the second physician chosen under the statutory requirement may not be embarrassed as to his treatment of the employee. The law further provides that upon summary hearing the Department may permit an employee to select a physician not on the panel.

Although these provisions are rarely invoked, they are implicit in the Compensation Act and should be fully recognized and followed when request is made by an employee.

CAN YOU PRACTICE WITHOUT A LICENSE?

The practice of medicine and surgery within this state requires a license. Even physicians just finishing their military service or moving to Wisconsin from another state *must* be licensed in this state before they enter active practice. Failure to complete licensure before beginning practice may subject the physician to criticism or disciplinary action.

Temporary licenses may be granted under special circumstances by the State Medical Examining Board. Emergency treatment and consultation with licensed Wisconsin practitioners may be undertaken by physicians not licensed in this state. But, the general rule is that a physician must have a Wisconsin license to practice in this state.

Reference: Sections 448.02(1), 448.03(3), 448.16, Wisconsin Statutes.

REFER CHILD PLACEMENT CASES TO THESE AGENCIES

LICENSED CHILD WELFARE AGENCIES:

Wisconsin Lutheran Child and Family Service, Inc., 6870 North 76th Street, Milwaukee 53223.

*Children's Service Society of Wisconsin, 610 North Jackson, Milwaukee 53202.

Catholic Social Services of the Archdiocese of Milwaukee, Inc., 207 East Michigan Street, Milwaukee 53202.

Catholic Social Service, Inc., 128 South Sixth Street, La Crosse 54601.

Catholic Social Service, 25 S. Hancock, Madison 53703.

Green Bay Diocese Apostolate (Catholic), 131 South Madison Street, Green Bay 54305.

Lutheran Children's Friend Society, 8138 Harwood Avenue, Wauwatosa 53213.

Lutheran Social Services of Wisconsin and Upper Michigan, 3200 West Highland Boulevard, Milwaukee 53208.

Jewish Family & Children's Service, The Plankinton Bldg., Suite 3185, 161 W. Wisconsin Avenue, Milwaukee 53203.

Methodist Children's Services of Wisconsin, 303 Price Place, Lincoln Bldg., Madison 53711.

PUBLIC AGENCIES:

*Wisconsin Division of Family Services (See page 76 for list of Regional Offices).

*Milwaukee County Department of Public Welfare, Child Welfare Division, 1220 West Vliet Street, Milwaukee 53205.

LICENSED MATERNITY HOMES:

Lutheran Maternity Home, 1910 South Avenue, La Crosse 54601.

Booth Memorial Hospital, 6306 Cedar Street, Wauwatosa 53213.

Rosalie Manor, 19338 West North Ave., Brookfield 53005.

St. Francis Maternity Residence, 11th and Market Streets, La Crosse 54601.

Marian Hall, 1725 Dousman Street, Green Bay 54303.

Fees for care in licensed maternity homes vary from $150 and up, depending on length of stay, covering prenatal care, confinement, and care after the child is born. Counseling services for unwed parents, both before and after the birth of the child, are provided by social agencies.

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* Nondenominational.

POISON INFORMATION CENTERS . . .

- approved by the Wisconsin Division of Health offer information on the chemical composition of brand-name products on a 24-hour day basis. Files are provided and kept up-to-date by the National Clearinghouse for Poison Control.
- recommend treatment to professional people or in certain emergencies, first aid procedure to lay callers.
- provide treatment for patients.
- keep a record of calls received, treatment advised or given, and disposition of case.
- report monthly to the Division of Health.

are located at:

Eau Claire
Luther Hospital
Phone: 832–6611 Ext. 227

Green Bay
Bellin Memorial Hospital
Phone: 437–9031 Ext. 257

Kenosha
Kenosha Memorial Hospital
Phone: 656–2201

Madison
University Hospitals
Phone: 262–3702

Milwaukee
Children's Hospital
Phone: 344–7100 Ext. 308

POISON CONTROL CENTERS . . .

- exist in many hospitals, including those listed above as Poison Information Centers. Not all Poison Control Centers are set up to give 24-hour service.
- provide treatment for patients.
- have standard references on toxicology and can answer many questions about potential poisons and treatment of cases. However, they do not have a complete file of the chemical composition of brand-name products such as the Poison Information Centers have.

This information provided by the
WISCONSIN DIVISION OF HEALTH
P. O. Box 309 Madison, Wis. 53701

Your Deadlines and Other "Musts"

Below are some of the deadlines and "musts" of a practicing physician:

TAXES

1. By January 15, 1971, you must pay the final installment of the estimated federal and Wisconsin tax on your 1970 income. This may necessitate an amended declaration by that date if you find that you underestimated 1970 income. A final income tax return for 1970, filed on or before January 31, 1971, accompanied by payment in full of the amount computed on the return as payable, will be treated as an amended declaration as of January 15 for both Wisconsin and federal purposes. Penalties are assessed for certain underestimating of taxes. These penalties and their avoidance are discussed in Section 6 below.

2. By January 31, you must:
   (1) File the employer's return of income taxes withheld in 1969 on Forms W-3 (Federal) and WT-7 (Wisconsin). These are summary report forms for the Forms W-2 (Federal) and WT-9 (Wisconsin), respectively.
   (2) Furnish a statement to employees on Forms W-2 (Federal) and WT-9 (Wisconsin) showing wages paid and amount of tax withheld during the calendar year 1970.
   (3) File fourth quarterly return for 1970 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (4) Furnish a statement to payees to whom interest, rent, compensation not reported on Form W-2 (Federal) and similar types of payments have been paid on Form 1099 (Federal).
   (5) File annual federal unemployment tax return on Form 940 (Federal).

3. By February 28, you must file a summary report on Form 1096 (Federal) attaching copies of the Forms 1099 (Federal) furnished to payees.

4. By April 15, you must:
   (1) File your personal income tax returns on Forms 1040 (Federal) and Form 1 (Wisconsin).
   (2) If a partnership, file your partnership income tax return on Forms 1065 (Federal) and 3 (Wisconsin).
   (3) File and furnish a copy to payees to whom interest, rent, compensation not reported on Forms WT-9 (Wisconsin) and similar types of payments have been paid on Form 9b (Wisconsin).

5. During 1971, you must:
   (1) File quarterly returns by April 30, July 31, and October 31 of income and Social Security taxes withheld on wages paid employees on Form 941 (Federal) and, for income taxes withheld on wages only, on Form WT-6 (Wisconsin).
   (2) File quarterly Wisconsin employer's unemployment compensation reports by the dates stated on the Form UC-101 furnished quarterly by the Department of Industry, Labor and Human Relations.

6. Estimates of Income; Quarterly Adjustments; Penalties.

   The first quarterly estimate of your 1971 income must be shown on Wisconsin and federal declaration forms which have to be filed, together with the estimated tax then due, by April 15, 1971. Other installments of the tax are due, together with amendments in the declaration should there be a change upward or downward, by June 15, and September 15, 1971. As to the final installment due in January, 1972, read the procedure described in Section 1, above.

   Excluding cases of willful understatement, a penalty is provided for underpaying taxes on declarations of estimated income. This penalty is a 6 percent assessment computed for each installment date on the difference between the amount paid and 80 percent of the amount which should have been paid. The penalty can be avoided if your quarterly installment payments meet one of three exception provisions following. (1) You may estimate your tax on the facts shown on your return for the preceding taxable year, but using current tax rates and personal exemptions. (2) Or, you may pay with each quarterly installment an amount at least equal to 80 percent of a tax then computed as if your income for the balance of the year remaining were to continue at the same rate. (3) Or, you may pay with each quarterly installment an amount at least equal to 90 percent of a tax computed at current rates on the actual taxable income for the months preceding each quarterly installment.

   The previously existing exception from the penalty based upon the payment of an amount at least equal to the tax shown on your return for the preceding taxable year was suspended by the federal government during the time the federal 10% surcharge existed.

7. Comments on Preceding Information.

   The preceding tax information is general and not exhaustive. Alternate methods of fulfilling these tax requirements do exist. Different forms

may be required. The forms and instructional sheets furnished with them should be consulted to determine appropriate alternate methods and forms to use.

The deadline dates apply to taxpayers who use the calendar year as their fiscal year.

Returns and filing dates for personal service corporations differ for certain of those discussed.

ANNUAL REGISTRATION IN WISCONSIN

Register with the Secretary, Medical Examining Board, Department of Regulation & Licensing, State of Wisconsin, 110 No. Henry Street, Madison, Wis. 53703, in the month of January. This registration will be on a form furnished by the Medical Examining Board and should be accompanied by the registration fee shown on that form. Sec. 448.07, Wis. Statutes.

ANNUAL NARCOTICS REGISTRATION

1. Register with the District Director, Internal Revenue Service, Milwaukee, Wisconsin, as required by the federal narcotics law, and pay the annual tax of $1.00 *before* July 1, 1971. I.R.C. 1954, Sec. 4751 and 4753. You are subject to penalties for overlooking either the registration or the tax.
2. Notify the District Director, Internal Revenue Service, Milwaukee, Wisconsin, of changes in place or places of business within 30 days to insure the legality of your narcotics license.

COMMITMENT REGISTRATION

Register with the county judge if you desire reference work on commitment proceedings for persons alleged to be mentally ill, mentally infirm, mentally deficient, inebriate, or drug addicts.

MALPRACTICE DEFINED

MALPRACTICE . . . Section 448.22 of the Wisconsin Statutes, quoted below, is concerned with the legal consequences to those who "treat the sick" without or beyond the limits of a license or certificate of registration. One such consequence is full liability for the penalties of malpractice even where it is the result of ignorance rather than negligence or lack of skill. The wording covers failure to perform or attempt to perform as well as actual performance.

The statute has application to such persons as chiropractors, podiatrists, or optometrists when they exceed their respective limited licenses or certificates.

Section 448.22 reads as follows:

> "Anyone practicing medicine, surgery, osteopathy, or any other form or system of treating the afflicted without having a license or a certificate of registration authorizing him so to do, shall be liable to the penalties and liabilities for malpractice; and ignorance on his part shall not lessen such liability for failing to perform or for negligently or unskillfully performing or attempting to perform any duty assumed, and which is ordinarily performed by authorized practitioners."

BLOOD GROUPING TEST FOR IDENTIFICATION

In an illegitimacy action, the trial court may order the mother, child, alleged father and others to submit to one or more blood grouping tests to determine whether the defendant can be excluded as the father of the child. The tests may be ordered, however, only after it has been determined that the tests would be relevant to the prosecution by the mother or the defense by the alleged father.

The results of the test are admissible only to prove that the defendant is not the father. Results which show only that the defendant might be the father are not admissible. Such tests must be conducted by a duly qualified physician or physicians each of whom has specialized in the field of clinical pathology or who possess a certificate of qualification as a certified pathologist issued by the American Board of Pathology.

Whenever relevant in a civil action to determine the parentage or identity of any child, person, or corpse, the court must direct any party to the action and any person involved in the controversy to submit to one or more blood tests. The results of the tests constitute conclusive evidence where exclusion is established and are receivable as evidence, but only in cases where a definite exclusion is established.

Reference: Sections 52.36 and 885.23, Wisconsin Statutes.

Charter Law of Medical Societies in Wisconsin

Chapter 148

148.01 (1) State society. The state medical society of Wisconsin is continued with the general powers of a corporation. It may from time to time adopt, alter and enforce constitution, bylaws and regulations for admission and expulsion of members, election of officers, and management.

(2) A member expelled from a county medical society may appeal to the state society, whose decision shall be final.

148.02 (1) County societies. The physicians and surgeons, not less than five in number, of the several counties, except those wherein a county medical society exists may meet at such time and place at the county seat as a majority agree upon and organize a county medical society, and when so organized it shall be a body corporate by the name of the medical society of such county, shall have the general powers of a corporation, and may take by purchase or gift and hold real and personal property. County medical societies now existing are continued with the powers and privileges conferred by this chapter.

(2) Physicians and surgeons who, before April 20, 1897, received a diploma from an incorporated medical college or society of any of the United States or territories or of any foreign country, or who shall have received a license from the state board of medical examiners, shall be entitled to meet for organization or become members of the county medical society.

(3) If there be not a sufficient number of physicians and surgeons in any county to form a medical society they may associate with those of adjoining counties, and the physicians and surgeons of not more than fifteen adjoining counties may organize a medical society under this chapter, meeting at such time and place as a majority agree upon.

(4) A county medical society may from time to time adopt, alter and enforce constitution, by-laws and regulations for the admission and expulsion of members, election of officers, and management, not inconsistent with the constitution, bylaws and regulations of the state society.

148.03 (1) Nonprofit plans for sickness care. The state society, or a county society in manner approved by the state society, shall have the power to establish in the state or in any county or counties therein, a nonprofit plan or plans for the sickness care of indigents and low income groups, and others, through contracts with public officials, and with physicians and others, and by the use of contributions, cooperative funds, and other means, provided only that free choice of physicians within such contracts shall be retained and that responsibility of physicians to patient and all other contract and tort relationships with patient shall remain as though the dealings were direct between physician and patient. Any person covered by or insured under such plan shall be free to choose for sickness care any medical or osteopathic physician, licensed to practice in Wisconsin who has agreed to abide by such plan according to its terms and no such physician or osteopath shall be required to participate exclusively in any such plan.

(2) Such plans shall be governed by ss. 200.26 and 204.31 (3m) and by no other law relating to insurance unless such law is referred to in ss. 200.26 and 204.31 (3m) and no law hereinafter enacted shall apply to such plans unless they are expressly designated therein or refer to such organizations as are responsible for the operation of such plans.

1841—THE SOCIETY CREATED BY TERRITORIAL LEGISLATION

The first statutory recognition of the State Medical Society was by act of the Legislative Assembly of the Territory of Wisconsin, in Act 53 of the Territorial Legislature of 1841. The organization of the Society was authorized, with the declaration that ". . . well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art. . ."

The organization meeting was set for the second Monday in January, 1842, at Madison, for the purpose of forming ". . . a society under the name and style of the Medical Society of the Territory of Wisconsin. . ." Drs. Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, were authorized by statute to conduct the initial organization of the Society.

FOR CORRECTION SEE p. 51 #8

Constitution and Bylaws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies, and, who shall also be members in good standing of the American Medical Association, and who have been certified to the headquarters of this Society, and all of whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

* COMMENT: In October 1964, the House of Delegates directed that action interpretive of the Constitution and Bylaws be indicated by annotation to the appropriate provision. This has been done beginning with 1964. This printing shows amendments through May 1970.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical societies, and one delegate representing each Section of the Society organized under the Bylaws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and Bylaws. It shall consist of the councilors and the immediate past president. The president-elect, the secretary, and the treasurer shall be ex officio members of the Council, but without the right to vote, and the president and speaker of the House of Delegates shall be ex officio members with such right to vote. A majority of its voting members shall constitute a quorum.

COMMENT: The above paragraph was amended in May 1963 to add the president and speaker of the House as voting members. In October 1964, the House approved a report to the effect that the Council has the authority to enforce the Constitution and Bylaws but not to change them. The action included an interpretation that the Council has the authority to determine its own committee structure and management policies. In the same year, the House recommended that the Council annually review services of Society consultants with consideration of such matters as utilization, efficiency and costs, with councilors reporting to the membership.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special sessions of the House of Delegates shall be called by the Speaker on written request of twenty delegates representing 10% or more of the component county medical societies, or on request of a majority of the Council. When a special session is thus called, the Speaker shall set time and place. The Secretary shall mail a notice to the last known address of each member of the House of Delegates at least twenty days before the special session is to be held. The notice shall specify the time and place of the meeting and the purpose for which the session is called, and the session shall consider no business except that for which it is called.

COMMENT: Section 3 was amended in May, 1965.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

Each councilor shall be nominated only by the elected delegates of the county medical society or societies in the district for which he is nominated.

No person shall hold more than one of such offices concurrently.

COMMENT: Section 1, above, was amended in May 1963 by adding the last paragraph.

SEC. 2. The officers, except the councilors and the speaker of the House of Delegates, shall be elected annually. The term of the speaker shall be for two years. The terms of the councilors shall be for three years. No individual shall be permitted to serve more than three successive three-year terms as councilor wherever possible, and no more than a total of six terms of service as councilor shall be permitted. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

COMMENT: Section 2, above, was amended in May 1963 to make the speaker's term of office two years. The fourth sentence on number of councilor terms was added in May 1965.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a bylaw, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or Journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BYLAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the Bylaws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered the annual addresses of the president and of the president-elect.

SEC. 2. The Council shall establish rules relating to requiring written papers of speakers. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in

its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

COMMENT: In May 1964 this section was amended to call for an interim session, but in May 1966 this provision was repealed effective January 1, 1967.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each forty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

COMMENT: Number used as basis for determining representation changed from fifty to forty in May 1966.

The term "full-paid members," as used in this section, includes regular members of the Society, life members, affiliate members, associate members, educational members, and members whose dues are waived or remitted by official action of the Society. Special service members, resident members, partial-pay members, and members who are delinquent in dues payments shall not be included in the term "full-paid members."

For purposes of this section, the number of fully paid members as of the close of the calendar year preceding the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society* by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One-fourth of the members of the House of Delegates registered, representing one-fourth of the county medical societies in the state, shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates, the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.
e. On Finances.

COMMENT: Reference Committee on Finances was authorized by the House of Delegates at May 1967 Annual Meeting.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

* Chapter XI, Section 8 was revised in 1958 to require reporting of delegates by the end of the calendar year. This section editorially revised to conform with 1958 amendment.

SEC. 6. The House of Delegates shall divide the state into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

COMMENT: In October 1964, the House of Delegates authorized a special committee of ten members, one from each congressional district, to study redistricting.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society thirty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a Committee on Nominations consisting of one delegate from each councilor district, and one delegate representing all of the scientific sections. The Committee on Nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being

made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the state and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the state by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

The secretary shall maintain certified copies of each component county society's constitution and bylaws, together with any amendments to the same.

COMMENT: In October 1964, the House of Delegates affirmed the secretary as the chief executive officer charged with the execution of policy without assuming policy-making powers. He shall assist the officers in making decisions and taking actions, and share his convictions and argue their merits as requested. See October 1964 transactions of the House, Report of Reference Committee on Resolutions and Amendments to the Constitution and Bylaws (December 1964 issue of WISCONSIN MEDICAL JOURNAL).

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice-speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice-speaker shall officiate during the unexpired term.

SEC. 7. The Council, as the executive body of the House, may devise an oath of office and have it administered through its Chairman to each constitutional officer and to each Councilor at an appropriate time and with an appropriate ceremony, upon their assuming office, such oath to state that each such officer and Councilor shall abide by and conduct his office in all respects in conformity with the Constitution and Bylaws of the Society and the decisions of its House and Council.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet during the annual session, and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting, for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

COMMENT: Section 1, above, was amended in May 1964 to permit the Council to determine time of its meeting during the Annual Meeting. In October 1964, the House affirmed that the annual report of the chairman "shall include all major actions and policy decisions" with the report to be approved by the House. It authorized also that resolutions explanatory or interpretive of the Constitution and Bylaws be incorporated by way of annotation to them.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. Each councilor shall arrange for an annual conference with the societies within his councilor district, either through individual meetings or district meetings, at which time information shall be brought concerning activities of the State Medical Society and component societies within the district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and Bylaws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and Bylaws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer. The Council may elect a vice chairman and create such further offices or combine or abolish them as it sees fit in the management of its affairs and in the discharge of its responsibilities.

SEC. 7. The Council may, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

When a councilor district initially qualifies for an additional councilor, such position shall be considered new and not a vacancy to which the Council is authorized to make an interim appointment. Such new position shall be filled by election at the next meeting of the House of Delegates in the manner provided by Article IX of the Constitution, and the initial term shall be so established as to maintain the election of substantially one-third of the councilors each year, as provided in Section 2 of said Article IX.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

- A Commission on Scientific Medicine
- A Commission on Health Information.
- A Commission on Public Policy.
- A Committee on Grievances.
- A Commission on Hospital Relations and Medical Education.
- A Committee Advisory to the Woman's Auxiliary.
- A Committee on Cancer.

COMMENT: In May 1967, the House of Delegates changed the name of the Commission on Public Relations and Communications to the Commission on Health Information.

Unless otherwise expressly provided in these Bylaws, each of these committees or commissions shall consist of five members, each of whom shall serve for a term of five years, and no person shall serve on any one of the above committees or commissions more than three consecutive terms; nor shall any member serve concurrently on more than one such committee or commission. One member of each of these committees or commissions shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee or commission the original appointments shall be for terms of one, two, three, four and five years, and thereafter for terms of five years each.

The chairman of each of the standing committees, or a member of the committee delegated by the chairman, shall make himself available to the appropriate reference committee of the House of Delegates for the purpose of amplifying or explaining the annual report of the standing committee of which he is a member.

SEC. 2. The Commission on Scientific Medicine shall consist of ten *appointed* members and the deans of the two medical schools in Wisconsin and the medical editor of the WISCONSIN MEDICAL JOURNAL. Each appointed member shall serve for a period of five years. The Commission on Scientific Medicine shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the scientific affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

COMMENT: Section 2, above, was amended in May 1964 by Resolution No. 30, which increased the number of appointed members from five to ten, and clarified the Commission's responsibility in that it shall be in charge of *scientific* affairs of the Journal.

SEC. 3. The Commission on Health Information shall consist of nine members appointed by the President of the Society. Appointments shall be so made that the terms of one-third of the members expire each year. The Commission on Health Information shall study, make recommendations, and implement approved activities to improve the distri-

bution of medical service to the public. It shall also be responsible for all matters relating to industrial, rural health and safety. The Commission shall direct the public information and health education programs of the Society and shall assist the component societies in the conduct of similar programs. It shall also conduct an internal professional relations program to encourage active participation of all members in the affairs of the Society.

SEC. 4. The Commission on Public Policy shall consist of seven representatives from the membership at large, a representative from each Scientific Section created under Chapter XIII, Section 1, the president, president-elect, and the secretary. Representatives from the Scientific Sections shall be appointed by the president of the State Medical Society from a panel of three nominees submitted by each section, or in event of the failure of any section to submit nominees, the president may appoint a member from that specialty group. As nearly as possible the terms of one-third of the members representing the Scientific Sections shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three year terms. Representatives from the membership at large shall be appointed pursuant to Section 1 of this Chapter. The Commission may elect its own executive committee of five members.

The Commission shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

COMMENT: The Commission on Public Policy was completely reconstituted by the House of Delegates in May 1964, by Resolution No. 29.

SEC. 5. The Committee on Grievances is empowered to receive complaints concerning individual physicians or groups of physicians, and initiate investigations under standing rules which it may establish. It may review decisions of local grievance or arbitration committees on appeal therefrom, but nothing in this section shall be construed as inconsistent with the provisions of Chapter VI relating to responsibilities of the Council.

It shall be the purpose of the committee to endeavor to effect an equitable adjustment or understanding, and to resolve such differences between physicians, or between physician and patient or other complainant.

The efforts of the committee may be extended into areas of interprofessional conduct, the development of appropriate codes of interprofessional relations, and its initial responsibility shall be to the Council of the State Medical Society. It shall consist of nine members appointed for terms of three years, one-third of such terms to expire annually.

Consistent with the special purposes of this committee, all committee records and files pertaining to such matters shall be treated as confidential, shall not be open to inspection by other persons, shall not be released for any purpose and shall not be subject to subpoena.

COMMENT: In May 1967, the House of Delegates repealed Section 5 of Chapter VII and substituted the present wording.

SEC. 6. The Commission on Hospital Relations and Medical Education shall consist of nine members, to be appointed by the President, with confirmation by the House of Delegates. As nearly as possible the terms of one-third of the members shall expire each year, with each member being appointed for a term of three years, except that initial appointments shall be for one, two, and three-year terms.

Its duties shall include the subjects of medical education, the interrelationships of the medical profession to hospital institutions, and all matters pertaining to the general subject of hospitals and the ability of the medical profession to provide quality medical care through their facilities.

The Commission shall be responsible to the Council in the interim between sessions of the House of Delegates, and the Council may assign one or more of its members to serve as liaison between the Council and the Commission.

COMMENT: In October 1964, the House of Delegates concurred in recommendation that this Commission retain jurisdiction of both hospital relations and medical education.

SEC. 7. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past president, the president, the president-elect, and the secretary. Its principal duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 8. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 9. The WISCONSIN MEDICAL JOURNAL shall be the official Journal of the Society.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. *Life Membership.* An active member who shall have been a member of his county and state medical societies in Wisconsin continuously for fifty consecutive years shall be offered the status of a life member, and if he accepts shall enjoy full membership privileges, but shall be exempt from the payment of dues or assessments. He shall receive a certificate of life membership.

SEC. 3. *Affiliate Membership.* An active member in good standing in his county society may, upon the recommendation of the secretary and president of the county medical society and with approval of

the State Medical Society, be granted affiliate membership with full voting and other privileges. Such membership shall be on an annual basis only, and shall be granted where such member suffers a physical or other disability preventing the practice of medicine with resulting serious financial reverses that would make payment of dues a matter of personal hardship.

SEC. 4. *Associate Membership.* A member in good standing in his county society, who has retired completely from the practice of medicine, may apply for associate membership. With approval of his county society and of the Council, such membership shall be granted without payment of annual dues.

SEC. 5. *Educational Memberships.* Physicians engaged solely in educational and research activities, and no part of whose income is derived from the private practice of medicine, shall be eligible to full membership in this Society, with all the privileges and responsibilities of membership, upon the payment of annual dues equal to approximately 75 per cent of that annually determined for full dues-paying members. Such members shall be issued a certificate denoting such special membership, and the content shall be approved by the Council. Application for such membership shall be endorsed by the chief of service or other physician in supervision.

SEC. 6. *Military Service Membership.* Members who are inducted into active United States military service shall be granted military service membership. Dues for such member are waived during term of service and for the balance of the year following separation from active duty.

SEC. 7. *Scientific Fellows.* The Council may confer upon any person engaged in teaching one or more of the basic sciences at an accredited college or university, and not holding the degree of Doctor of Medicine, the status of Scientific Fellow. Scientific Fellows shall pay no dues or assessments, shall receive the Wisconsin Medical Journal, and shall be eligible to attend scientific sessions of the Society.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society may create a similar classification.

COMMENT: Section 7, above, was created by the Council as Resolution No. 27 and adopted by the House of Delegates in May 1964.

SEC. 8. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 9. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and Bylaws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and bylaws shall have been submitted to the Council and received its approval. Where a county medical society has lost or misplaced its constitution and bylaws, the model constitution and bylaws for county medical societies, as last approved by the Council, shall be deemed to apply.

COMMENT: Section 1, above, was amended in May 1964 by Resolution No. 28, by adding the last sentence.

SEC. 2. Only one component medical society shall be chartered in each county.

COMMENT: The House of Delegates in October 1964 recommended that county medical societies in their constitutions and bylaws limit successive terms of officers, increase size of boards of directors, and have wide representation on nominating committees.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician, who holds an unlimited license to practice medicine and surgery, and whose principal practice is within the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of Constitution and Bylaws, either or both as may be necessary, the county society may require of an applicant for membership that he shall have practiced within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the Society.

A member of a component society whose license has been revoked, suspended, or voluntarily surrendered, shall be dropped from membership automatically as of the date of revocation, suspension, or voluntary surrender. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician's county society membership must be held in that county in which his principal practice is located. However, a physician living near a county line may hold his membership in that county most convenient for him to attend meetings, on permission of the component society in which county he maintains his principal place of practice.

A member who removes his principal practice from within the territorial limits of a component medical society in which he holds membership, to the territory of another component of the State Society, shall not be eligible to continue his membership in the first such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew, or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and Bylaws, either or both as may be necessary, a county society

may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of five years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III. Such resident members shall have the right to vote and hold office.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this state, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

When a member in good standing in a component society removes his principal practice outside the borders of this State, he may continue his active membership in such component society and in the State Society by fulfilling all requirements of membership except residence pending his acceptance as a new or transfer member by the society of the area to which he has transferred his practice; provided, the period of such continuing memberships in this State shall cease upon his acceptance by a society in the new area of practice, and shall in no event continue beyond two full calendar years after that in which he transferred the location of his practice.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. Each component county society shall elect one or more delegates, for a minimum term of two calendar years, and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2. of these Bylaws. The term of office shall be pursuant to the constitution and bylaws of the county medical society but shall begin on January 1 of the year succeeding the election of such delegate. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society by the end of each calendar year preceding the year in which such delegates are elected to serve. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

COMMENT: In Section 8, above, the two-year term was enacted by the House of Delegates in May 1964.

SEC 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committeemen shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

SEC. 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its constitution and bylaws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

No dues shall be assessed against such member during term of service or for the balance of the year following separation from active duty. Special service membership shall lapse at the close of the calendar year of the separation of each such member from active duty.

CHAPTER XII

THE ACADEMY OF MEDICAL HISTORY

Membership in the Academy shall be composed of those interested in preserving medical history in Wisconsin. The Academy shall have the power to elect its chairman and other officers, and the office of the secretary of the State Medical Society shall provide secretarial assistance to it.

Annual dues shall be fixed by the Academy and shall not exceed $10 per year. The Academy is empowered to accept contributions to its projects and may solicit funds in behalf of the Society. All funds of the Academy shall be segregated, and expenditures from them shall be made under direction and supervision of the Academy, subject to approval of the Council.

Special membership certificates may be issued to those who become members of the Academy, and displays may be developed by the Academy for exhibit at the Society's Annual Meeting and elsewhere.

CHAPTER XIII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, if so recommended by the Council from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIV

SECTION 1. These Bylaws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid over for one day.

SEC. 2. Upon the adoption of this Constitution and these Bylaws, all previous Constitutions and Bylaws are thereby repealed.

SALE OF CONTRACEPTIVES AND ABORTIFACIENTS

Only licensed physicians and registered pharmacists may sell contraceptives and abortifacients or articles appropriate to that use and sold with the intention that they be so used. In no event may such article, drug or preparation be sold to any unmarried person.

Prohibited also is the advertising or public display of such articles for sale, or the manufacture, purchase or possession of a machine or device appropriate for vending contraceptives or abortifacients.

Violation of the provisions of this statute subjects the violator to a fine of one hundred dollars to five hundred dollars ($100 to $500), or imprisonment in a county jail not to exceed six months, or both.

Reference: Section 450.11, Wisconsin Statutes.

LAW REQUIRES SILVER NITRATE TO PREVENT INFANT BLINDNESS

The state law requires, and the State Medical Society recommends, the continued use of silver nitrate for the prevention of ophthalmia neonatorum.

Physicians are warned to use only the 1% solutions of silver nitrate prepared by the State Division of Health and distributed free to each physician through local health officers. The law also requires the physician to use the solution as directed in the prepared instructions.

Some birth certificates filed with the State Division of Health reveal that Wisconsin physicians are utilizing penicillin as a substitute for silver nitrate. However, professional circles still debate the efficacy of substitutions for silver nitrate. The State Medical Society's Division on Maternal and Child Welfare of the Commission on State Departments believes there is not enough evidence to recommend the use of substitutes. The American Medical Association has expressed the same attitude.

The use of any substitute for silver nitrate in the prevention of ophthalmia neonatorum subjects a physician to a fine of $100. In addition, it may subject him to a suit for malpractice.

Reference: Section 146.01, Wisconsin Statutes.

STATE MEDICAL SOCIETY OF WISCONSIN

330 EAST LAKESIDE STREET

MADISON, WISCONSIN

The "Home" of the State Medical Society on the south shore of Lake Monona houses the Wisconsin Medical Journal, the Society's Blue Shield plan, general administrative offices, dining room, meeting room, and Council room. Nearly 300 committee and other meetings are held here annually.

Services to Members

Health Educational Activities

Voluntary Health Agency Contacts

Student Loans

Grievance Services

Museum of Medical Progress and Stovall Hall of Health

Executive Office Services

The Wisconsin Medical Journal

Life Insurance

Disability Income Protection

Wisconsin Work Week of Health

WPS Protection

Films on Drug Abuse

Open Panel Program under Workmen's Compensation

Postgraduate Education Programs

Physician Placement

Medicolegal Consultation

Professional Liability Consultation

Public Relations

Legislative Representation

Governmental Agency Contacts

Medical Economic Advice

Members, State Medical Society of Wisconsin*

Adell:
Tolentino, J. Q.

Algoma:
Ancheta, Valentino
Hopkins, R. G.
March, J. F.
Papendick, D. E.

Allenton:
Fisher, R. S.

Alma:
Bachhuber, M. O.

Amery:
Arneson, O. N.
Byrne, W. R.
Dasler, H. A.
Ford, K. K.
Marra, M. G.
Schroeder, Daniel J., Jr.
Whitlark, F. L.

Antigo:
Beattie, B. W.
Blink, D. V.
Cromer, R. W.
Curran, W. P.
Fox, T. C.
Garbisch, F. H.
Garritty, J. E.
Habel, Theodor
Holm, W. A.
Kassis, H. J.
Lambert, J. W.
McKenna, J. E.
Moemound, J. O., Jr.
Moore, G. E.
Roth, E. J.

Appleton:
Anderson, J. G.
Belden, A. D.
Bonner, J. N.
Bravick, D. D.
Brei, F. A.
Carlson, G. W.
Chandler, W. W.
Claypool, Blaine, Jr.
Cline, R. S.
Cunningham, P. M.
Curry, J. C.
Dafoe, W. A.
Danford, H. G.
DeCock, R. D.
Dungar, C. F.
Engstrom, D. P.
Erchul, J. W.
Evangelista, T. L.
Fenlon, C. E.
French, G. A.
Gallaher, D. M., Jr.
Giffin, W. S.
Gmeiner, J. E.
Gomilla, S. G.
Graves, M. D.
Green, C. J.
Gross, H. T.
Grubb, W. B., Jr.
Hale, William H.
Hamel, H. H.
Harris, J. S.
Hauch, F. M.
Haza, B. J.
Hodges, P. C., Jr.
Huberty, F. J.
Kagen, M. S.
Keane, K. M.
Kennedy, R. O.
Kinde, R. R.
Kitzerow, E. B.
Konz, S. A.
Laird, J. W.
Landis, R. V.
Loescher, T. M.
Luther, T. W.
Manesis, J. G.
McCanna, P. R.
Meighan, P. P.
Meyers, C. L.
Mielke, J. E.
Miller, E. J.
Mueller, G. F., Jr.
Neidhold, C. D.
Nichols, G. P.
O'Boyle, R. F.
Petersen, G. J.
Plouff, L. T.
Querol, J. T.
Raney, E. H.
Rankin, F. J.
Reichle, R. I.
Richards, W. R.
Russell, J. H.
Ryan, T. A.
Santos, G. P.
Sargent, J. M.
Savage, G. W.
Slegrist, K. J.
Simenson, R. S.
Slette, D. R.
Sullivan, J. F.
Taylor, A. C.
Veum, J. S.
Warren, J. L.
Weissler, J. B.
Williams, L. P.
Wright, Frank, Jr.
Young, J. J.
Zeiss, E. J.
Zeiss, J. C.

Argyle:
Hunter, R. E.

Ashland:
Bargholtz, W. E.
Jauquet, J. M.
Koeller, A. A.
Kreher, J. E.
Larson, H. H.
Mercer, W. C.
Morrow, K. A.
Prentice, B. C.
Prentice, J. W.
Sandin, H. V.
Sneed, R. J.
Stanley, R. A.
Tucker, W. J.

Athens:
Regehr, E. H.

Augusta:
Moland, O. G.
Thieda, E. S.

Baldwin:
Grieben, L. R. J.
May, J. A.
Olson, C. A.
Torkelson, L. B.

Bangor:
Ruppenthal, K. P.

Baraboo:
Hannan, K. D. L.
Hansel, R. G.
Holmen, G. J.
Huth, M. F.
Lewis, J. M.
Pearson, C. R.
Slebert, J. T.
Vangor, D. W.
Weston, E. L.

Barron:
MacMillan, D. G.
Strang, C. J.
Whaley, R. C.

Bayside:
Meyer, J. O.

Beaver Dam:
Barajas, Rafael
Bayley, H. G., Jr.
Bender, R. I.
Bergen, P. M.
Boock, R. F.
Cook, R. S.
Damon, R. A.
Davis, T. C., Jr.
Drescher, G. G.
Ehrhardt, A. A.
Erickson, N. W.
Funcke, Wm. E.
Glunz, P. R.
Klomberg, G. H.
Kores, A. B.
Link, D. L.
Molina, Rudolfo
Qualls, C. L.
Richards, W. G.
Ritzenthaler, D. O.
Rowan, T.
Schulz, N. H.
Snook, W. H.
Szweda, J. A.
Taake, E. R.
Urbanek, R. E.
Vrabec, A. P.
Way, R. W.
Welsch, J. M.
Wohlwend, E. B.

Belgium:
Dorr, R. H.

Belleville:
Donlin, W. F.

Beloit:
Babb, J. L.
Baldwin, R. M.
Beltran, J. C.
Brillman, L. P.
Carney, C. M.
Carter, K. L.
Chancey, R. L.
Fitzgerald, W. M.
Flarity, T. H.
Frank, Jordan
Glesne, O. G.
Gold, K. I.
Gunderson, R. H.
Hebble, W. M.
Jones, E. T.
Katz, Mayer
Kleppe, L. W.
Lakritz, L. W.
Lang, T. J.
Manning, T. A.
Matthews, G. C.
Mauermann, W. J.
Pollard, W. H., Jr.
Pruett, W. A.
Qul, F. L.
Raube, H. A.
Salvador, F. E.
Sanderson, R. J.
Scholten, W. A., Jr.
Schwaegler, R. R.
Springberg, J. C.
Thayer, R. A.
Tuftee, A. O.
Twyman, A. H.
Woodington, G. F.

Berlin:
Gimenez, A. R.
Koch, H. C.
Koch, J. C.
Osicka, S. R.
Seward, L. J.
Slevers, D. J.

Big Bend:
Raschbacher, J. L.
Zarbock, F. M.

Black River Falls:
Aprahamian, Charles
Daniells, A. S.
Hanley, L. L.
Holder, R. L.
Krohn, Eugene
Krohn, Robert
Noble, J. H.
Thurow, R. M.

Blair:
Schneider, O. M.

Bloomer:
Asplund, M. W.
Clauson, C. T.
Murphy, P. W.

Bouduel:
Grover, W. W., Jr.
Stuff, Patricia J.

Boscobel:
Freymiller, E. F.
McNamee, J. R.
Mueller, C. E.
Randall, E. M.

Brillion:
DeArteaga, Julio

Brodhead:
Stuessy, M. W.

Brookfield:
Alberti, J. B.
Bemis, E. L.
Bogle, W. C.
Fick, K. R.
Fitzpatrick, P. J.
Franzen, L. D.
Gager, W. E.
Hart, T. N.
Huizenga, B. A.
Jennison, M. R.
Jurisic, Anthony
Lim, R. A.
Lipscomb, C. R.
Luedke, D. M.
Mann, D. H.
Meves, T. F.
Mueller, K. H.
Nemcek, A. A.
Olsen, R. N.
Pavlic, R. S.
Popp, M. J.
Restrepo, Roberto
Roth, D. A.
Schaefer, K. C.
Sewell, R. H.
Stoklos, Michael
Teresi, J. L.
Toepfer, R. A.
Viel, R. S.
Wells, R. K.
Werts, K. G.
Wood, D. L.
Wright, I. V.

Brown Deer:
Bellehumeur, Gerald
Darling, W. A.

Brownsville:
Friedrich, L. E.
Ries, M. F.

Bruce:
Raduege, W. E.
Whalen, M. L.

Burlington:
Baker, D. J.
Batsleer, R. L.
Erickson, L. W.
Gander, E. P.
Granzeau, H. W.
Krismer, G. J.
McNeel, Laird
Sroka, Wm. C.
Van Liere, J. D.
Wheaton, R. C.

Cadott:
Bowe, C. T.
Haines, B. J.
Zenner, C. E.

Caledonia:
O'Brien, M. J.

Cambridge:
Amundson, K. K.
Nemec, George, Jr.

Campbellsport:
Hoffmann, L. A.

Casco:
Kerscher, E. J.

* As of Dec. 31, 1970.

Cassville:
David, J. J.

Cedarburg:
Blanchard, P. B.
Huckaby, A. L.
Hurth, O. W.
Katz, H. J.
Kippenhan, J. E.
Laufenburg, Herbert
Misch, Allen

Cedar Grove:
Jensen, J. S.

Chetek:
Adams, R. W.
Bannister, F. M.
Bender, J. P.
Esswein, J. L.
Pierpont, D. B.

Chilton:
Humke, K. R.
Klein, M. H.
Knauf, J. W.

Chippewa Falls:
Carlson, S. D.
Dahl, D. A.
Graber, Rex E.
Hatleberg, C. B.
Hatleberg, E. A.
Henske, W. C.
Kemper, C. A.
Picotte, L. W.
Rahn, B. F.
Sazama, J. J.
Windeck, J. L.

Clear Lake:
Campbell, L. A., Jr.

Clinton:
Mejia, G. B.
Pili, D. B., Jr.

Clintonville:
Arnold, W. G.
Bate, L. C.
Caskey, H. S.
Topp, C. A.

Cochrane:
Meili, E. A.

Colby:
Koch, James W.
Pfefferkorn, E. D.

Coleman:
Graner, L. H.

Colfax:
Felland, O. M.

Colgate:
Stein, R. W.

Columbus:
Chell, C. F.
Poser, J. F.
Poser, R. F.
Shearer, C. E.

Cornell:
Hendrickson, R. L.

Cottage Grove:
Vogt, G. H.

Crandon:
Moffet, D. V.
Rathert, Burton S.

Crivitz:
Settlage, H. A.

Cross Plains:
Lappley, W. F.

Cuba City:
King, C. S.
Stone, M. M.
Taylor, H. W., Jr.

Cudahy:
Armagan, Senekerim
Chelius, C. J.
Cornell, J. W.
Fine, J. M.
Fons, J. W., Jr.
Frederick, J. J.
Gomez, S. W.
Homsey, J. J.
Jerofke, A. M.
Kash, S. H.
Lando, D. H., Jr.
Landsberg, Manfred
Latorraca, Rocco
Marcich, Z. P.
Nuyda, D.
Potos, W. B.
Rabor, A. A., Jr.
Sirin, K. F.
Tabet, R. C.
Vitulli, V. N
Wadina, G. W.

Cumberland:
Anderson, R. M.
Jirsa, H. O.
Lund, R. E.

Darlington:
McGreane, N. A.
Olson, Lyle L.
Ruf, D. F.

Deerfield:
Ingwell, C. L.

De Forest:
Grinde, J. M.

Delafield:
Olsen, L. C. J.

Delavan:
Fitzgerald, G. P.
Galgano, R. S.
Martin, J. E., Jr.
O'Keefe, F. L.
Roesler, M. J.
Smiley, G. A.
Werbel, H. J.
Woods, Wm. C.

Denmark:
Hering, G. V.

De Pere:
Adamsky, V. D.
Merline, G. B.
Waldkirch, B. P.
Waldkirch, R. M.

Dodgeville:
Buckner, H. M.
Downs, D. R.
Hamilton, W. P.
Rasmussen, N. G.

Dousman:
Pecarski, Miodrag
Varma, Som D.

Durand:
Bryant, R. J.
Myers, M. E.
Springer, J. P.

Eagle River:
Colgan, J. J.
Jacobson, L. L.
Oldfield, R. A. A.

East Ellsworth:
Klaas, F. B.

East Troy:
Flynn, R. T., Jr.
Kohn, Louis
Young, W. N.

Eau Claire:
Aitken, H. M.
Angell, D. C.
Bates, P. J.
Beckfield, W. J.
Bjurstrom, R. O.
Brousseau, E. R.
Brown, F. J.
Brown, J. R.
Brown, R. C.
Buckley, R. A.
Cameron, W. G.
Dibble, J. B.
Edson, J. D.
Fink, R. J.
Finucane, P. J.
Frank, R. C.
Fuson, H. S.
Gericke, J. T., Jr.
German, K. L.
Giffen, G. G.
Gonlag, Harry
Griffith, D. R.
Haag, A. F.
Halgrimson, K. W.
Henke, F. W.
Henke, S. L.
Hilker, A. W.
Hill, E. F.
Hoff, D. E.
Hudson, R. F
Huston, H. C.
Ihle, C. M.
Kass, R. M.
Kelley, W. M.
Kennedy, R. L.
Kilkenny, T. E.
Klein, A. J.
Larkin, W. B.
Lorenz, A. A.
Lotz, R. M.
Manz, W. R.
Martins, J. K
Mautz, W. T.
McAfee, G. D.
Midelfort, Peter A. H.
Miller, D. F.
Miller, G. E.
Moberg, T. D.
Nester, H. D.
Nezworski, L. G.
Niver, E. O.
Ostenso, R. S.
Owen, G. E.
Paulson, W. O.
Raymond, L. A.
Richards, R. R.
Schulz, Emil
Sorensen, H. E.
Spelbring, P. G.
Sperry, V. A.
Stang, H. M.
Stewart, K. E.
Strand, R. C.
Thimke, H. E.
Tobin, J. M.
Wahl, G. E.
Walter, K. E.
Walter, Wm.
Willison, D. M.
Wishart, J. H.

Edgar:
Schulz, H. A.

Edgerton:
Boulet, W. J.
Burpee, G. F.
Cohen, D. A.
Falk, V. S., Jr.
Pavlik, K. K.
Shearer, T. M.
Sumner, W. C.

Elcho:
Dailey, D. W.

Elkhart Lake:
Heiden, H. H.
Martineau, J. E.

Elkhorn:
Bill, K. C.
Helmbrecht, M. G.
Mol, H. R.
Petersen, R. D.
Rawlins, J. A.
Rogers, R. J.
Schrock, J. B., Jr.
Sorenson, E. D.

Ellsworth:
Jonas, E. R.

Elm Grove:
Andres, F. I.
Bauer, C. A.
Denio, M. J., Jr.
DeVault, M. L.
DiMiceli, Ettore, Jr.
Dudenhoefer, P. A.
Erwin, C. J. R.
Erwin, C. P.
Foster, L. L.
Grade, J. O.
Headlee, C. R.
Hepperla, R. L
Klingbeil, R. E.
Matelcka, W. E.
Millington, P. E.
Myers, S. C.
Olsen, E. H., Jr.
Redlin, R. R.
Rouman, W. C.
Schmidt, R. A.
Settima, A. L.
Shockley, B. F., Jr
Sinclair, E. P.
Smits, R. H.
Van Gilder, J. H.
Wilson, S. D.
Wisniewski, J. H.

Elmwood:
Springer, F. A.

Elroy:
Balder, R. B., Jr.

Ettrick:
Rogne, C. O.

Evansville:
Gray, R. J.
Gray, Roger S.

Fall Creek:
Zboralske, F. F.

Fennimore:
Howell, E. C.
Shields, C. H., Jr.
Stupek W. S.

Fond du Lac:
Becker, N. O.
Benneyan, R. N.
Bissegger, Arnold
Borsack, K. K.
Carlovsky, R. E.
Cerny, F. J.
Charles, J. E.
Cullen, R. E.
Devine, J. C.
Flanagan, C. M.
Gardner, L. C.
Guth, H. K.
Hagel, Hans
Huebner, J. S.
Hutter, A. M.
Jones, L. E.
Keenan, L. J.
Kendell, W. G.
Klef, H. J.
Koll, J. H.
Lawrence, D. L.
Leonard, C. W.
Llewen, B. E.
Longstreth, C. R.
Mauthe, Howard
McBride, F. F.
McCormick, D. W.
McCullough, James C.
McCullough, John C.
McLane, Hugh J.
Meislnger, G. F.
Moore, C. E.
Myers, W. E.
Pallin, Josephine N.
Parrish, J. G., Jr.
Pawsat, E. H.
Peters, John
Peterson, C. R.
Rupple, J. H.
Schlichting, J. E.
Schroeder, R. W.
Shahrokh, D. K.
Sharpe, H. R., Jr.
Sisk, J. A.
Smith, D. A.
Smith, E. V., Jr.
Steube, R. W.
Sullivan, E. J.
Theis, E. H.
Theisen, S. A.
Thomas, H. R., Jr.
Treffert, D. A.
Twohig, D. J., Jr.

Vetter, E. W.
Vrtilek, M. R.
Waffle, R. L.
Waldschmidt, W. J.
Weber, D. R.
Wier, J. S.
Wojta, W. C.
Yockey, J. C.

Ft. Atkinson:
Aufderhaar, H. W.
Bates, D. E.
Beran, F. V.
Gilchrist, R. T.
Gueldner, L. H.
Handeyside, R. G.
Hanson, O. H.
Harris, J. J.
Hunsader, H. N.
Lagman, R. M.
Russell, J. C.
Sholtes, C. A.

Fox Point:
Peters, L. M.
Silberman, Jack

Franklin:
Atamdede, Aysel

Franksville:
Gass, H. I.

Frederic:
Fischer, W. A.
Schwab, D. F.

Friendship:
Gascoigne, C. C.
Janssen, M. L.
Tamayo, Alfonso
Weihe, A. R.

Galesville:
Alvarez, R. L.
Moen, C. B.
Rohde, E. P.

Genoa City:
Dekker, Cornelis

Germantown:
Lastrilla, R. S.

Gillett:
Reyes, Metodio

Glendale:
Brazy, R. R.
Mendeloff, Elton
Wegmann, G. H.

Glenwood City:
Limberg, A. W.
Limberg, P. W.

Grafton:
Fueredi, Adam
Pelant, K. F.

Grantsburg:
Hartzell, R. L.

Green Bay:
Adair, S. E.
Andrew, R. C.
Angus, D. C.
Austin, S. D.
Babbitt, L. D.
Belson, M. J.
Benkendorf, Charles
Beno, T. J.
Blackburn, M. D., Jr.
Blahnik, C. L.
Block, R. T.
Boersma, J. J.
Bramschreiber, J. L.
Brusky, A. H.
Brusky, E. S.
Brusky, J. D.
Brusky, R. J.
Caffrey, J. F.
Clark, E. V., Jr.
Cook, F. D.
Crawford, C. W.
Cross, W. M.
Danaher, H. H.
Dega, F. J.
Denys, G. F.
Dettmann, J. E.
Donarski, D. P.
Draheim, J. H.
Dupont, A. J.
Edelblute, L. H.
Erickson, M. R.
Falk, M. J.
Forbes, K. A.
Ford, J. L.
Ford, W. W.
Freedman, A. L.
Gallagher, D. J.
Gehring, J. V.
Goelz, J. R.
Grace, J. B.
Green, J. R.
Griggs, S. L.
Gruesen, R. A.
Guthrie, J. M., Jr.
Halnes, A. W.
Hart, L. E.
Hitch, O. M.
Holder, D. H.
Holder, J. B.
Hoops, H. J., Jr.
Jacobs, E. B.
Jensen, R. E.
Johnston, R. E.
Jones, W. D.
Kaftan, G. R.
Kaufman, J. E.
Kenny, J. A.
Killeen, E. R.
Killing, J. A.
Kuehl, F. O.
Kulkoski, Bernard
Kullerstrand, D. S.
Leicht, T. R.
Le Mieux, G. E.
Lynn, T. E.
MacMullen, Wallace, II
Marnocha, J. R.
Martin, J. E.
McCarey, A. J.
McCormick, R. A.
McGuire, G. E.
McIntyre, J. A.
McKenna, D. H.
McManus, J. T.
McNeal, W. E.
Mickle, K. C.
Miller, L. C.
Mills, J. M.
Milson, B. I.
Milson, Louis
Milson, S. E.
Mokrohisky, J. F.
Murphy, R. J.
Myers, R. L.
Nadeau, E. G.
Nadeau, E. G., Jr.
Nellen, J. W.
Neu, V. F.
Nicolaus, W. H.
Nishioka, Hiro
Novotny, C. G.
Ottum, J. A.
Oudenhoven, R. C.
Peters, H. R.
Philipp, L. D.
Rahr, H. C.
Randall, J. H.
Richardson, B. L.
Robb, J. J.
Rose, R. J.
Rothe, C. A., Jr.
Sandmire, H. F.
Schibly, W. J.
Schmidt, R. T.
Schneider, W. F.
Schumacher, J. P.
Sehring, F. G.
Shea, D. W.
Sherwood, D. L.
Shinners, G. M.
Sipes, D. R.
Slightam, P. E.
Smith, C. C.
Stauff, G. R.
Stiennon, O. A.
Stoehr, B. J.
Stoll, W. M.
Sullivan, Donel
Theller, G. J., Jr.
Thompson, L. L.
Troup, R. H.
Troup, R. L.
Troup, W. J.
Urban, Frank
Utrie, J. W.
Von Heimburg, Roger
Walker, T. F.
Wallerius, J. F.
Wentworth, A. F.
Wineinger, D. M.
Wochos, R. G.
Zucker, K. L.

Greendale:
Anacleto, E. F.
Brown, R. J.
Gabriel, R. P.
Herrington, R. E.
Kottke, M. A.
Kuglitsch, E. F.
Martins, R. R.
Spiegelhoff, D. R.
Taugher, P. J.
Wengelewski, H. B.
Westley, William, Jr.

Greenfield:
Weis, T. W.

Green Lake:
Barbour, J. H.
Leininger, A. T.

Gresham:
Litzen, F. L.

Hales Corners:
Altstadt, J. F.
Bottum, M. W.
Clemence, J. A.
Czajka, J. J.
Damiano, N. F.
Gillespie, C. J.
Grosshandler, S. L.
Jachowicz, R. B.
Kuban, D. J.
La Susa, T. J.
Pagedas, A. C.
Pierce, D. F.
Sortor, R. F.
Wolf, R. C.

Hartford:
Algiers, J. L.
Donahue, Parnell
Hoffmann, J. G.
Hoffmann, W. C.
Kern, T. J.
Mally, M. J.
Monroe, M. E.
Nickels, R. J.
Quackenbush, E. C.
Quandt, V. V.

Hartland:
Chambers, R. K.
Ridley, J. F.
Samuelson, Clarence

Hawthorne:
Farias, O. A.

Hayward:
Baertsch, L. M.
Callaghan, D. H.
Eder, R. L.
Hussa, J. F.
Sahs, M. H.
Sharp, D. S.
Strapon, Paul, III

Hazel Green:
Farbstein, M. E.
Klein, G. J.

Hilbert:
Pinney, J. C.

Hillsboro:
Boston, T. E.
Sanford, L. L.

Hollandale:
Marshall, S. B.

Horicon:
Karsten, F. A.

Hortonville:
Bergwall, J. G.
Towne, W. H.

Hudson:
Anderson, M. G.
Bourget, G. E.
Cornwall, M. A.
Hopkins, G. J.

Hurley:
Martinetti, D. J.

Independence:
Meyer, C. F.

Iola:
Hollero, N. J.

Iron River:
Edwards, P. K.

Jackson:
Albrecht, J. E.

Janesville:
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Baker, C. S.
Betlach, Dorothy W.
Betlach, Eugene H.
Bostian, K. E.
Chicks, C. O.
Deeds, E. C.
Dodge, R. K.
Donkle, M. J.
Frechette, F. M.
Gilbertsen, C. R.
Gredler, G. P.
Gutmann, G. E.
Hansen, T. R.
Hartlaub, E. S.
Healy, W. G.
Holland, R. A.
Job, E. J.
Kalember, R. L.
Karzel, R. P.
Knepel, Donald
Kochell, R. L.
Kronquist, G. E.
Lakritz, Amrum
Levin, Harland
Llewellyn, M. B.
Matzke, Robert F.
McNichols, E. F.
McSweeny, A. J.
Nash, C. B.
Neeno, Katsumi
Nienhuis, H. D.
Nuzum, T. O.
O'Brien, J. N.
Odland, P. K.
Olson, D. R.
Otterholt, E. R.
Overton, R. S.
Papadakes, N. G.
Pember, J. F.
Pennepacker, J. S.
Peters, E. E.
Peterson, Geo. H.
Plautz, A. C., Jr.
Purdy, M. F.
Ram, V. A.
Rau, Esther L.
Reinardy, A. L.
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Russo, F. R.
Sabado, E. F.
Sargeant, T. S.
Schroder, John R.
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Sholl, P. R.
Smith, D. A.
Snodgrass, H. M.
Thomas, G. L.
Tordoff, J. J.
Tregoning, P. C.
Vitacca, R. J.
Vogel, T. L.

Jefferson:
Busse, A. A.
Quandt, C. E.
Quandt, R. W.
Siedenburg, Richard

Johnson Creek:
Wendt, F. A.

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Haessly, F. G.
Heath, H. J.

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Bachhuber, A. E.
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Behnke, G. A.
Boyd, G. L.
Cherkasky, Simon
Jeffrey, J. S.
Russo, J. G.
Skibba, J. P.
Wolfmeyer, W. W.

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Armstrong, G. F.
Ashley, R. W.
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Bilak, R.
Bjork, H. A.
Bode, M. J.
Bonell, B. T.
Burhani, A. W.
Burnett, R. G.
Capelli, P. A.
Conzelman, D. R.
Cozine, W. I
Creighton, L. H.
Creswell, C. M.
Cruz, N. R.
Davis, D. W.
DeFazio, S. F.
Donnell, W. S.
Duncan, J. T., Jr.
Fai, L. L.
Ferwerda, J. R.
Fraser, W. E.
Gandhi, K. V.
Garren, J. T., Jr.
Goldstein, D. N.
Halfon, Nesim
Hauschild, W. A.
Heck, J. A.
Hill, B. Spalding
Holt, S. H.
Horsley, D. B.
Huberty, L. H.
Kappus, H. C.
Kent, L. T.
Kleinpell, W. C.
Lipman, W. H.
Lokvam, L. H.
Lutz, J. J.
Meeter, U. L.
Mercado, R. C.
Miller, David
Milliken, L. D., Jr.
Morrow, C. A.
Mudge, W. A., Jr.
Nice, M. L.
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Patel, A. P.
Pearson, J. B.
Pechous, C. E.
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Peterson, C. E.
Powell, R. A.
Rafferty, H. P.
Rattan, W. C.
Rauen, L. M.
Richards, J. N.
Ruehlman, D. D.
Ruffio, A. F.
Sattler, C. A.
Schlenker, L. T.
Schulte, G. C.
Schwartz, G. J.
Schwartz, H. L.
Siegel, Morris
Swift, W. J.
Turner, Lewis, III
Wadina, G. S.
Wagner, H. B.
Weber, G. R.
Welsch, R. G.
Whetstone, O. H.
Williams, F. C., Jr.
Wilson, R. E.
Wood, Fredrick, Jr.

Kewaskum:
Edwards, R. G.

Kewaunee:
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Lanier, Patricia F
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Wits, E. W.

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Theiler, A. C.
Twohig, G. J.

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Gage, Ralph S.
Knoedler, W. H.

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Damp, O. E.
McGinnis, H. J.

Kohler:
Forkner, W. A.
Rowe, D. M.

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Aiken, R. E.
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Anderson, E. M.
Anderson, N. P.
Anderson, P. D.
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Bach, A. C.
Bogart, K. C.
Brailey, A. G., Jr.
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Buchman, D. M.
Caplan, R. H.
Carlsson, E. S.
Cejpek, K. O.
Clemons, J. E.
Cook, A. A.
Copps, S. C.
Corser, D. H.
Da Costa, W. C.
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Dietz, P. C.
Durst, J. B.
Edland, R. W.
Egan, G. J., Jr.
Ellenz, G. B.
Elston, A. C. V.
Ernst, F. W.
Felion, P. L.
Fisher, A. L.
Flynn, R. E.
Fox, J. C.
Gallagher, F. J.
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Getz, Kaare
Gilbert, R. L.
Goodnough, D. E.
Green, R. M.
Guernsey, Gretchen
Gundersen, A. E.
Gundersen, A. H.
Gundersen, A. L.
Gundersen, Cameron
Gundersen, G. A., Jr.
Gundersen, Gunnar
Gundersen, J. H.
Gundersen, S. B., Jr.
Gundersen, T. E.
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Hartigan, J. M.
Haug, S. L.
Hayden, J. W.
Helliesen, P. J.
Henke, T. K.
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Howard, R. S.
Hullck, P. V.
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Kalfayan, Bernard
Keimowitz, R. M.
Keller, K. E.
Kisken, W. A.
Leiby, R. W., Jr.
Link, C. E.
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McGarty, M. A.
McKee, D. C.
McMahon, R. E.
McNamara, T. B.
Meis, P. J.
Mildelfort, C. F.
Miner, E. B.
Morgan, W. A.
Morris, D. L.
Murphy, G. B., Jr.
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Nickel, F. A.
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Orman, E. S.
Overholt, E. L.
Perry, E. L.
Phillips, P. W.
Pribek, R. A.
Ramlow, R. W.
Rasmus, R. B.
Richter, J. R.
Satory, J. J.
Schaldach, F. A.
Scheurich, Mary B.
Schmidt, C. F.
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Schneeberger, E. J.
Schuldes, R. E.
Seager, G. M.
Sevenants, J. J.
Shealy, C. N.
Shields, J. C.
Simones, J. J.
Skemp, C. A.
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Smith, Martin J.
Taebel, D. W.
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Tendero, R. A.
Thompkins, D. G.
Uhrich, G. I.
Wahl, J. W.
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Wolf, F. H.

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Bennett, R. P.
Murphy, J. E.
Pagel, H. F.

Lake Geneva:
Beattie, J. W.
Bischof, H. F.
Hindall, B. C.
Hudson, E. D.
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Rauch, A. M.

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Eck, G. E.
Effenhauser, Manfred
Leering, Hendrik
Liebenow, R. R.
Netzow, E. J.
Peterson, M. G.

Lake Tomahawk:
Craite, E. J.

Lancaster:
Bauman, K. L.
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Carey, H. W.
Hillery, G. C.
Houghton, E. M.
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McCay, Sophia

Land O' Lakes
Eickhoff, E. C.

Laona:
Castaldo, E. F.
Ovitz, E. G.

Lena:
Rose, J. F.

Little Chute:
Van Lieshout, F. X.

Lodi:
Irwin, W. G.

Loyal:
Hable, A. P.

Luxemburg:
Majeski, H. E.

Madison:
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Ainslie, R. B.
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Allin, R. N.
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Andringa, C. L.
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Ansusinha, Tamnit
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Babcock, S. W.
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Backwinkel, K. D.
Baker, R. M.
Bamforth, Betty J.
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Barta, R. A., Jr.
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Batson, J. F.
Beck, J. P.
Beilman, R. L.
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Bennett, Maxine
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Blank, R. J.
Bloodworth, J. M. B., Jr.
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Brew, Barbara A.
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Brindley, B. I.
Britton, D. M.
Brodhead, Wm. T.
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Brown, J. G.
Brueggemann, J. G.
Bryan, G. T.
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Carter, H. M.
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Chosy, L. W.
Chun, R. W. M.
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Clinton, G. L.
Cohen, Marcus
Collins, R. F.
Combs, James A.
Connors, C. B.
Cookson, D. U.
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Crummy, A. B., Jr.
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Cunningham, M. A.
Curet, L. B.
Curreri, A. R.
Dahl, D. S.
Dally, A. D.
Daugherty, D. A.
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Davidson, P. L.
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Dean, F. K.
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Demergian, Vaughn
Derus, Gerald J.
de Venecia, Guillermo
Dibble, P. A.
Dickie, Helen A.
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Dimond, W. B.
Doehlert, C. A.
Dollard, J. E.
Donovan, T. J.
Doolittle, J. W.
Dortzbach, R. K.
Doty, J. W.
Dudiak, Stephen
Duehr, P. A.
Ebling, P. R.
Eckert, G. L.
Ecklund, L. A.
Ehrlich, F. E.
Eichman, P. L.
Epstein, Stephan
Erickson, M. T.
Ewell, G. H.
Fabiny, R. J.
Farrell, R. X.
Fellner, C. H.
Forster, F. M.
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Foseid, Oscar F.
Fosmark, C. A.
Foster, M. A.
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Froelich, R. D.
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Garnett, G. M.
Gascolgne, J. T.
Geocaris, Konstantin
Geppert, C. H.
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Giles, L. T.
Gladstone, H. P.
Glover, B. H., Jr.
Golden, F. F.
Golden, P. B.
Gollin, F. F.
Gordon, E. S.
Grab, J. A.
Graf, R. A.
Graham, D. T.
Grahek, A. S.
Grassy, R. G.
Graven, S. N.
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Halleck, S. L.
Hamacher, J. E.
Handa, Yoshio
Handy, G. H.
Hank, G. C.
Hansen, M. F.
Harbour, J. D.
Harper, C. S.
Harper, S. B.
Hartridge, T. L.
Head, R. W.
Healy, J. R.
Heiden, J. D.
Hendricks, R. J.
Hennen, R. J.
Hibma, O. V.
Hill, N. A.
Hinck, V. C.
Hirschler, C. W.
Hobbins, W. B.
Hoesley, H. F.
Hoff, A. D.
Hoffman, P. A.
Hogan, L. H.
Holmgren, L. E.
Hopkins, C. E.
Horswill, C. W.
Howe, G. E.
Huffer, J. M.
Hummer, F. L.
Hurst, D. W.
Hussey, J. L.
Hutson, C. F.
Iams, A. M.
Inhorn, S. L.
Jackson, C. R.
Jackson, R. H., Jr.
Jaeschke, W. H.
Jahn, C. L.
Janicek, D. R.
Janis, Martin
Javid, Manucher
Joachim, F. G.
Johnson, C. J.
Johnson, E. E.
Johnson, F. K.
Johnson, R. O.
Johnson, S. A. M.
Johnson, S. B.
Jones, R. J.
Jorris, E. H.
Juhl, J. H.
Kabler, J. D.
Kanner, A. V.
Kaskey, E. T.
Kaveggia, Laszlo
Keepman, Jay P.
Kemp, T. S.
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Kilpatrick, Leslie G.
Kincaid, C. K.
Klatt, K. M.
Klutzow, F. W.
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Kolner, E. H.
Kopp, W. L.
Koppa, J. F.
Korbitz, B. C.
Korbitz, R. F.
Korst, D. R.
Kraft, J. W.
Kriss, Frederick C.
Kroncke, G. M.
Krout, R. M.
Kundert, P. R.
Kunin, C. M.
Lacke, C. L.
Land, J. F.
Lange, R. D.
Langheim, W. E.
Ledbetter, M. K.
Lemmer, K. E.
Levy, R. M.
Lewis, W. C.
Liebl, E. R.
Lindblade, J. A.
Linden, R. E.
Lindgren, Richard
Link, R. W.
Lobeck, C. C.
Logan, Richard
Longley, B. J.
Lubar, H. S.
Lubing, H. N.
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Lucas, G. L.
Lucia, G. E., Jr.
Luetke, W. V.
Lulloff, R. S.
Lyne, B. W.
Lyons, W. H.
Mackman, Sanford
Madsen, P. O.
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Mahaffey, H. W.
Malec, J. P.
Maloof, G. J.
Manhart, Harold E.
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Mannis, K. S.
Marlow, Gordon V.
Maultsby, M. C., Jr.
McAleavy, J. C.
McAweeny, W. J.
McBeath, A. A.
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McCarthy, T. M.
McClung, John L.
McDermott, John P.
McDonough, K. B.
McIllece, Patricia E.
McIntosh, J. F.
McLeod, P. A.
McMillan, W. G.
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Michael, S. R.
Middleton, W. S.
Miezio, Stanley
Miller, J. E.
Miller, M. H.
Mohs, F. E.
Moore, J. N.
Morledge, John
Morrissey, J. F.
Mortensen, O. A.
Moss, H. V., Jr.
Mueller, G. C.
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Murley, H. D.
Mussari, P. F.
Mussey, W. C.
Myers, F. L.
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Nahn, C. E.
Neaves, Noe
Nesbit, M. E.
Neuhauser, C. A.
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Noll, D. J.
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Okagaki, H. I.
Olsen, C. O.
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Olson, R. W.
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Owen, R. H.
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Peckham, B. M.
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Piper, P. G.
Pitot, H. C.
Pitts, F. R., Jr.
Pizer, E. F.
Pois, A. J.
Preizler, Josef
Price, D. O.
Prouty, L. R.
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Puestow, K. L.
Pulcina, J. D.
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Pyle, R. W.
Quisling, A. A.
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Rahm, J. P., Jr.
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Rank, P. P.
Rapkin, M. A.
Reeb, K. G.
Reed, C. E.
Reese, H. H.
Reznichek, C. G.
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Rich, F. M.
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Rikkers, Henry
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Roberts, L. M.
Rock, William
Rogers, S. C.
Roggensak, G. F.
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Rose, J. W.
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Roth, Harry
Rotter, Royal
Rounds, W. M.
Rowe, G. G.
Rudy, R. C.
Rundle, F. L.
Rusch, K. H.
Ryan, A. J.
Ryder, E. K., Jr.
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Salick, J. A.
Samp, R. J.
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Schekler, W. E.
Schmidt, C. S.
Schmitz, R. C.
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Schneiders, E. F.
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Schuster, D. S.
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Steffen, D. H.
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Steinmetz, G. P., Jr.
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Stoops, C. W.
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Sundstrom, W. R.
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Tormey, T. W., Jr.
Toussaint, J. B.
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Tweeten, J. K.
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Van Gemert, J. G.
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Vingom, C. O.
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Walton, J. D.
Warrick, Louis F., Jr.
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Waskow, W. L.
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Waters, R. F.
Watson, J. D.
Way, A. B.
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Wegner, G. P.
Weinstein, A. B.
Welke, E. G.
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Wyner, S. F.
Yale, C. E.
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Manitowoc:

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Best, J. D.
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Bush, R. D.
Davis, N. S., Jr.

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Larsen, J. R.
Lynch, J. D.
MacLean, C. R.
May, J. H.
Miller, H. P., Jr.
Perry, T. K.
Pick, D. M.
Puestow, R. C.
Radl, C. J.
Randolph, R. C.
Randolph, W. C.
Rauch, W. A.
Rees, T. H.
Schaefer, H. E.
Scherping, W. H.
Schroeder, N. C.
Simon, G. M.
Smejkal, W. F.
Stannard, G. H., Jr.
Steckbauer, J. W.
Strong, R. G.
Teitgen, T. A.
Thorpe, R. F.
Van Dreel, R. A.
Wall, C. E.
Whereatt, R. R.
White, W. F.
Yost, R. G.

Marathon:

Kampine, C. E.
Ware, Robert J.

Marinette:

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Boren, C. H.
Boren, Clark H.
Boren, J. A.
Boren, J. W., Jr
DeWitt, R. J.
Eckstrom, P. T.
Koepp, C. E.
Krapohl, A. J.
Magnin, Dean
Moss, K. J.
Murray, R. C.
Pinegar, K. G.
Pinkerton, J. D.
Stripling, B. D.
Zeratsky, J. D.

Markesan:

Adams, H. G.
Cupery, D. P.
Plueddeman, P. M.

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Schmidt, C. W.

Marshfield:

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Bersalona, Fernando B.
Browell, J. N., Jr.
Burns, J. L., Jr.
Burrill, R. E.
Carlson, R. D.
Custer, G. S., Jr.
Dean, W. R.
Doege, K. H.
Dovenbarger, W. V.
Emanuel, D. A.
Fischer, H. K. J.
Fischer-Williams, Mariella
Fletcher, F. W.
Floyd, C. P.
Gottschalk, P. G.
Gouze, F. J.
Govindaswamy, P.
Griese, G. G.
Haight, R. P., Jr.
Hansen, R. L.
Hansotia, P.
Hardacre, J. M.
Heywood, R. M.
Heywood, W. H.
Hinke, D. H.
Hinke, M. L.
Holtey, W. J.
Johnson, S. E.
Kinkella, A. M.
Kruse, Francis, Jr.
Kunkel, J. A.
Lawton, B. R.
Lewis, R. F., Jr.
Lohrenz, F. N.
Magnin, George E.
Manier, J. W.
Mason, R. W.
Maurer, W. J.
Miller, R. W.
Mills, E. Grady
Moffat, N. A.
Mulvaney, J. J.
Myers, W. O.
Nikolal, T. F.
Norfleet, R. G.
Olsen, T. G.
Opitz, J. C.
Ottensmeyer, D. J.
Ousley, J. L.
Pederson, D. P.
Porter, G. E.
Ptacek, L. J.
Reyes, C. N., Jr.
Rice, T. J.
River, G. L.
Rodriguez, Justo
Rowe, R. J.
Rupel, J. W.
Salibl, B. S.
Sampson, C. E., Jr.
Sarmicanic, S.
Sautter, R. D.
Schloesser, L. L.
Schorr, W. F.
Sparks, G. M.
Suits, J. J.
Toyama, W. M.
Ulmer, Richard H.
Vedder, C. A.
Vedder, J. S.
Voss, D. M.
Walters, E. W.
Waters, H. S.
Williams, G. H.
Winemiller, R. H.
Wyman, J. B.
Zurek, W. Z.

Mauston:

Grlffin, V. M.
Hess, J. S., Jr.
Strong, Jack
Vedner, J. H.

Mayville:

Bachhuber, F. G.
Bachhuber, M. W.
Parish, G. A.

Mazomanie:

Schultz, Isadore

McFarland:

Arnesen, R. B.

Medford:

Keuer, J. R.
Meyer, W. W.
Nystrum, L. E.
Nystrum, R. C.

Menasha:

Burrows, Thomas
Conway, J. E.
De Morest, H. F., Jr.
Gustafson, G. E., Jr.
Hathaway, D. S.
Hildebrand, F. L.
Hildebrand, G. B.
Hildebrand, W. B.
Jensen, F. G.
Jensen, R. A.
Kidd, H. L.
Nebel, J. R.
Newby, K. G.
Pier, P. E.
Pratt, G. N., Jr.
Reilly, G. D.
Schwei, G. P.
Walnscott, P. E.
Wessell, G. R.

Menomonee Falls:

Blbler, R. H.
Brennan, W. M.
Davasligil, Halil
Dawes, R. B.
De Guzman, E.
Dempsey, K. J.
Domann, W. A.
Dougherty, P. J.
Drayer, H. D.
Foley, J. J.
Hardman, D. R.
Harrington, K. J.
Heyrman, D. J.
Hofbauer, T. A.
Hoffman, J. R.
Klopf, H. M.
Kuwayama, S. P.
Limjoco, U. R.
Riesch, J. D.
Schloemer, H. F.
Schmidt, R. D.
Temple, R. L.
Zimmerman, R. C.

Menomonie:

Drescher, A. A.
James, J. R.
Lee, S. R.
McMahon, A. E.
Melms, F. A., Jr.
Miech, M. J.
Natwick, R. D.
Quilling, P. A.

Mequon:

Ackerman, E. J.
Handrich, T. A.
Janssen, W. C.
Scholz, H. F. W.

Merrill:

Bayer, L. J.
Bigalow, J. F.
Braun, W. E.
Janowiak, J. S.
Karabey, A. B.
Lane, F. C.
Lewinnek, Walter
Mllenbah, J. D.
Ravn, E. O., Jr.
Vechinski, T. O.

Middleton:

Ameduri, Ardo
Anderson, R. B.
Baske, R. F.
Heighway, T. F.
Leonard, T. A., Jr.
Maguire, D. W.
Sarto, G. E.

Milton:

Burdick, H. L.
Lyons, R. P.

Milton Junction:

Holmes, J. F.

Milwaukee:

Aaberg, T. M.
Abrams, J. E.
Ackerman, D. S.
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Adlam, R. T.
Agarwal, A. B.
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Altman, D. P.
Altshuler, C. H.
Alverno, Luca
Andersen, J. T.
Ansfield, D. J.
Apfelberg, H. J.
Appleby, K. B.
Apte, U. S.
Aquino, Manuel
Arkins, J. A.
Armbruster, J. L.
Aronow, C. B.
Asinas, I. L.
Askot, M. M.
Asma, R. M.
Aster, R. H.
Atamdede, Y. I.
Atkinson, C. T.
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Auer, J. E.
Ausman, D. C.
Azcueta, Ester S.
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Babby, Louis
Bachhuber, E. A.
Backus, E. A.
Baier, A. R.
Baird, W. W.
Baker, D. A.
Baker, F. C.
Baker, V. L.
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Banaszak, E. F.
Banda, P. N.
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Barnett, S. M.
Baron, J. J.
Barrock, J. J.
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Batayias, G. E.
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Baumle, B. J.
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Bell, J. E.
Bender, B. I.
Benjamin, H. B.
Benner, M. H.
Bercey, J. E.
Berglund, G. A.
Bergmann, G. J.
Berk, R. A.
Berman, Alexander
Berner, C. L.
Bernhard, G. C.
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Bernhard, V. M.
Bernhart, E. L.
Bernstein, H. H.
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Bickler, E. P.
Biehl, M. D.
Biever, P. H.
Biller, J. H.
Bines, M. M.
Black, S. B.
Blankstein, S. S.
Bleil, D. C.
Blount, W. P.
Bogost, Bruce
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Bolger, J. V.
Bond, John M.
Bond, J. T.
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Bookhamer, J. W.
Borman, M. C.
Borowski, T. P.
Bortin, M. M.
Botticelli, J. T.
Boulanger, W. J.
Bourne, C. W.
Bourne, N. W.
Bourne, R. B.
Boxer, L. M.
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Boyd, Andrew, Jr.
Brah, W. A.
Brand, W. D.
Brennan, J. J.
Brewer, B. J.
Brillman, C. R.
Bruno, D. S.
Bruns, W. T.
Brzezinski, E. A.
Budny, C. L.
Bunkfeldt, Frederick, Jr.
Burchman, S. L.
Burg, E. A., Jr.
Burgess, G. F., Jr.
Burnell, E. L.
Buscaglia, A. T.
Buscaglia, C. J.
Bussey, A. D.
Buszkiewicz, T. S.
Buttles, A. J.
Byrne, R. R.
Byrne, R. W.
Cafaro, A. F.
Cafaro, J. R.
Caine, Donald
Callan, R. E.
Calvy, T. L.
Cardy, J. D.
Carek, D. J.
Carl, E. F.
Carlson, D. J.
Carpenter, F. J.
Cary, J. F.
Cash, I. I.
Casper, W. T.
Cassldy, R. H.

Caton, J. R.
Ceci, G. E.
Cervenansky, A. A.
Chalos, W. P.
Chamberlain, J. O.
Chandrasekharan, R. G.
Chapman, B. L.
Charles, J. D.
Chase, Jules
Chisholm, D. E.
Chojnacki, S. L.
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Chrzan, D. J.
Churchill, B. P.
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Clark, D. O.
Clark, K. M.
Clarke, B. E.
Clasen, W. E.
Claudon, D. B.
Coffey, J. M.
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Cogan, L. J.
Coheen, J. J.
Cohen, A. M.
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Coles, E. L.
Collentine, G. E., Jr.
Collins, D. P.
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Collopy, M. C.
Collopy, P. J.
Conen, W. J.
Conley, J. E.
Conlon, H. J.
Conmy, M. F.
Conrad, A. B.
Conroy, C. F.
Conway, J. D.
Conway, J. P.
Cordes, J. E.
Cornfield, A. L. M.
Cornfield, J. R.
Coron, A. J.
Correll, H. L.
Costello, A. C.
Cox, T. J.
Cron, R. S.
Crottier, C. J.
Cutting, H. M.
Cyrus, A. E., Jr.
Dale, H. L.
Daley, G. M.
Danforth, R. C.
Danocup, R. J.
Danziger, Lewis
Darien, G. G.
Darin, J. C.
Darling, F. E., Jr.
Darling, S. J.
Datka, G. L.
Davidoff, D. E.
Davidoff, I. Z.
Davies, J. A.
Davis, D. P.
Davis, Jean P.
DeGroat, F. L., Jr.
Deiparine, Alfonso, Jr.
DeLeo, N. C.
Deifs, Eleanor
Del Rivero, A. Cartes
Demeter, N. D.
DeOliveira, M. M.
Derse, F. R.
Dettmann, Frederick
Devitt, J. S.
Deysach, L. J.
Dhuey, J. N.
Diamond, C. O.
Dieterle, C. H.
Dix, C. R.
Docktor, John P.
Dooley, J. E.
Dorn, A. S.
Dorn, R. G.
Dricken, H. N.
Drozewski, M. F.
Drvaric, E. J.
Duchelle, R. A.
Duffy, Haydon R.
Dundon, J. R.
Dunker, G. O.
Dunst, C. G.
Dvorak, H. J.
Dyken, P. R.
Easom, H. A.
Eby, L. G.
Egan, W. J.
Ehrhart, J. T.
Eichenberger, C. R.
Eisenberg, E. E.
Elconin, A. N.
Elconin, D. V.
Elson, M. W.
End, Edgar
End, J. A.
Engbring, N. H.
Enzer, Norbert
Epperson, K. D.
Epstein, Ely
Erbes, John
Esser, J. H.
Evans, S. M.
Faber, C. A.
Falsetti, F. P.
Fant, J. R.
Farrell, H. J.
Feiges, L. M.
Feiman, L. H.
Felizmena, R. C.
Ferroy, C. A.
Fetherston, J. P., Jr.
Fetherston, T. J.
Fetherston, W. C.
Fidler, Alan B.
Fledier, H. W.
Fiester, R. F.
Fine, R. A.
Fine, S. W.
Finlayson, W. E.
Finn, C. J.
Fitzgerald, R. E.
Flanary, L. M.
Flatley, T. J.
Flemma, R. J.
Fletcher, H. A.
Flint, C. H.
Flood, R. E.
Flynn, G. F.
Foerster, F. E.
Foerster, H. J.
Foerster, H. R., Jr.
Foley, D. V.
Foley, T. J.
Foregger, Richard
Fox, M. J.
Fox, Meyer S.
Fox, Milton J.
Frackelton, W. H.
Francis, R. J.
Franke, G. H.
Franklin, Isadore
Franklin, R. L.
Freedman, M. S.
Fricano, Salvatore
Friedman, B. J.
Friedman, J. E.
Friedrichs, E. S.
Frisch, J. G.
Frisch, R. A.
Fritz, R. D.
Fritz, R. J.
Fruchtman, R. B.
Fruth, R. B.
Gaenslen, F. G.
Galang, M. T.
Galasinski, R. E.
Gale, H. H.
Gallen, W. J
Gandhi, S. K.
Gandy, T. I.
Gani, M. A.
Garens, R. W.
Garland, T. F.
Garner, L. L.
Garry, M. W.
Gasparri, P. G.
Gaunt, J. J.
Gaynon, I. E
Gebert, W. H.
Gecht, E. A.
Geigler, J. E.
Geimer, N. F.
Geist, J. E.
Gelfman, Morris
Gendlin, N. A.
George, K. S.
Gerhardstein, R. P.
Gettleman, S. T.
Giannattasio, V. A.
Gilbert, Joseph
Gilier, Herbert
Gimenez, J. L.
Gingrass, R. P.
Gingrass, Ruedi P.
Gjud, A. M.
Glassner, D. M
Glickiich, Lucille B.
Glicklich, Marvin
Gilenke, C. F.
Glisch, W. P.
Goerke, R. F.
Goetz, R. A.
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Goldberg, Nat.
Goldberg, S. C. B.
Goldberger, Esther W.
Goldberger, R. J.
Golding, J. L.
Goldstein, P. H.
Gonyo, J. E.
Goodman, J. A.
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Goodman, P. P.
Gorder, A. C.
Gordon, N. F.
Gorens, S. W.
Gorenstein, Leonard
Gramling, J. J.
Graziano, S. A.
Gregorio, F. Q.
Greenberg, A. I.
Greenberg, Maurice
Griffith, J. C.
Groh, J. A.
Grossberg, Josette B.
Grossman, N. M.
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Grossman, T. W.
Grossmann, E. E.
Gruender, J. E. M.
Grueninger, A. J.
Gryniewicz, Michael
Guhl, J. F.
Gumerman, G. J.
Gute, D. B.
Guten, G. N.
Gutglass, M. F.
Guzzetta, P. C., Jr.
Habbe, J. E.
Habeck, E. A. W.
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Hall, Mary A.
Halloran, W. R.
Halser, J. G., Jr.
Hamm, H. J.
Hammes, D. A.
Hansen, A. C.
Hansher, Ervin
Hansen, P. T.
Hanson, E. R.
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Hardgrove, Maurice
Harkavy, Raymond
Harper, C. W.
Harrington, E. T.
Harris, B. A.
Harris, T. A.
Hartwick, J. P.
Haug, J. F.
Haugh, J. J., Jr.
Hauser G. C.
Haushalter, L. E.
Hausmann, P. F.
Heidner, F. C.
Heinzelmann, C. M.
Heller, T. A.
Hellmuth, G. A.
Henschel, A. B.
Hermann, A. H.
Herrington, J. K.
Hickey, C. H., Jr.
High, A. L.
High, H. C., Jr.
Higley, R. A.
Hilger, Wm. A.
Hilrich, Nathan M.
Himes, Joseph
Hinson, R. E.
Hipke, M. M.
Hirsch, S. R.
Hirschboeck, J. S.
Hitz, J. B.
Hiabac, R. J.
Hodgson, N. B.
Hoelscher, K. K.
Hoffman, Wm. K.
Hogan, J. P.
Holbrook, A. A.
Hollenbeck, S. W.
Horwitz, S. F.
Hotter, J. T.
Houghton, W. J., Jr.
House, J. W., Jr.
Hovis, W. F., Jr.
Howard, T. J.
Howards, L. A.
Huber, H. H.
Hughes, G. R.
Hughson, D. T.
Hunkel, V. H.
Hurley, J. D.
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Hussey, Clara V.
Hussussian, Jacques
Huston, E. S.
Huston, J. H.
Huston, John
Hyslop, V. B.
Ibach, H. F.
Imp, J. F.
Inda, Gregory
Iturralde, Rafael
Ives, D. G.
Jacobs, P. A.
Jacobson, F. J.
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Jaekels, M. T.
Jahn, R. P.
James, L. J.
James, R. L.
Jansen, R. K.
Janusonis, P. A.
Jefferson, R. A.
Jekel, J. M.
Jelenchick, E. J.
Jennings, T. F.
Jermain, L. F.
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Johnson, Frances
Johnson, H. W.
Johnson, J. A.
Johnson, J. H.
Johnson, K. O.
Johnson, R. C.
Johnson, W. D.
Johnston, T. L.
Jordahl, Clarence, Jr.
Judge, T. A.
Jurczyk, W. G.
Jurevics, I. R.
Jurgens, G. H.
Jurishica, A. J.
Just, J. F.
Kagen, A. E.
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Kah, W. W.
Kalb, C. H.
Kallas, G. J.
Kamper, D. G.
Kane, A. M.
Kanin, H. J.
Karen, Robert
Karlin, H. R.
Karr, J. K.
Kassowitz, K. E.
Kastelic, Robert
Katz, R. H.
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Kaufman, K. K.
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Keane, S. P.
Kearns, J. W.
Kebbekus, R. A.
Kelble, J. A.
Keller, T. A.
Kelley, W. B.
Kennedy, K. S.
Kenwood, S. N.
Kerrigan, G. A.
Kersting, D. W.
Keskey, C. W.
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Kidder, T. M.
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Kilian, A. D.
Kindwall, E. P.
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King, J. J.
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Kirmse, T. W.
Kiselow, M. C.
Kissling, A. C.,
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Klees, V. M.
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Klein, Morris
Kleinerman, L. B.
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Klink, D. D.
Kloehn, R. W.
Kniaz, Albert
Koch, M. J.
Kocovsky, C. J.
Koenig, R. R.
Koepke, D. E.
Kohler, E. E.
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Kohn, S. E.
Korducki, Stanley A.
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Kretchmar, L. H.
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Kretzschmar, W. A.
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Krill, R. J.
Kriz-Hettwer, Rose
Krumbiegel, E. R.
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Kult, A. S.
Kurzon, Alvin M.
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LaFond, D. J.
Landis, C. W.
Lane, G. H.
Lange, R. L.
Langjahr, A. R.
Larkey, Jay A.
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Laubenheimer, Roger
Lawler, P. J.
Leben, Carol D.
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Lee, OK Soon
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Lescher, H. N.
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Levenson, Ina
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Lewis, J. D.
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Linn, J. C.
Lipo, R. F.
Lipscomb, T. C.
Litzow, J. R.
Liu, C. C.
Locher, C. J.
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Longe, W. G.
Lopez, Basilio
Lorton, Rhoda J.
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Geenen, J. E.
Gehring, C. A.
Gerol, A. Y.
Gillett, G. N.
Goldstein, F. P.
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Grinney, L. R.
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Johnson, P. S.
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Keland, H. B.
Khoja, Sherali
Kolmeier, K. H
Konnak, Wm. F.
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Desch, C. A.
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Salan, Sam
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Schrank, R. E.
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Dyson, B. C.
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Hermann, W. C.
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Miller, M. D.
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Stern, L. S.
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Ziebert, A. P.
Zimmer, J. F.
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Keiser, O. S.
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Esener, Ismail_____Rome, Ga.
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Farnsworth, R. W.
_____Pomona Beach, Fla.
Fernandez, P. B.
_____Minneapolis, Minn.
Fisk, N. M.___Los Altos Hills, Calif.
Forrestal, T. P.
_____McConnelsville, Ohio
Frawley, D. D._____Sun City, Ariz.
Gemmill, W. D._____Toledo, Ohio
Geretti, R. J._____Tucson, Ariz.
Gilmar, R. L._____Indianapolis, Ind.
Gloss, A. J._____Bensonville, Ind.
Gottlieb, A. M._____Palo Alto, Calif.
Guillermo, Remedios
_____Sherman Oaks, Calif.
Hargarten, L. W.____Oakland, Calif.
Harned, R. K._____Omaha, Nebr.
Heath, Hunter, III
_____Silver Spring, Md.
Hededus, A. A._____Hemet, Calif.
Heeb, H. J.
_____Howey in the Hills, Fla.
Heil, J. U._____Poway, Calif.
Heise, H. A._____Arvada, Colo.
Henderson, R. A._____Boston, Mass.
Herzog, J. V._____Sun City, Ariz.
Hunter, A. L.____Green Valley, Ariz.
Huth, E. P._____Englewood, Fla.
Jaeger, J. G._____Belmont, Mass.
Jasculca, J. H.
_____San Francisco, Calif.
Kelly, G. F._____Berkeley, Calif.
Killins, W. A._____Carmel, Calif.
Kimmelsteil, Paul
_____Oklahoma City, Okla.
Kinsey, J. L._____San Diego, Calif.
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Kratchovil, C. H.__Kalamazoo, Mich.
Kreissl, L. J., Jr.__Santa Rosa, Calif.
Kurtz, E. C._____Foster City, Calif.
Larson, A. N._____Cincinnati, Ohio
Levis, E. H._____Westlaco, Tex.
Lindner, Anton_____Brooklyn, N. Y.
Litofsky, Arthur
_____Silver Spring, Md.
Lloyd B. E._____Mt. Prospect, Ill.
Lowe, J. W._____Scottsdale, Ariz.
Malit, B. B._____Long Beach, Calif.
McCabe, John_____Austin, Tex.
McLaughlin, J. T.__Costa Mesa, Calif.
Montgomery, T. B.__New York, N. Y.
Nachacel, D. P., Jr.
_____Grosse Pointe Woods, Mich.
O'Donnell, M. J.__Wadsworth, Kans.
Overgard, A. W.
_____Farmington, Minn.
Owen, J. D._____Cave Creek, Ariz.
Palmer, K. A._____Philadelphia, Pa.
Parnell, Francis J.
_____San Rafael, Calif.
Patterson, R. H._____Chicago, Ill.
Pember, A. H._____Lake Wales, Fla.
Pesarillo, Servando___Kokomo, Ind.
Peterson, F. N._____Wayland, Mass.
Pfefferkorn, E. B.
_____Culver City, Calif.
Pierson, P. S._____Pottstown, Pa.
Pinell, O. C._____Anoka, Minn.
Pitlyk, P. J._____Burlingame, Calif.
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Pratt, Mary_____Boston, Mass.
Pugh, G. J._____Punta Gorda, Fla.
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Roller, M. D._____Franklin, Ind.
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Sazama, F. B._____Scottsdale, Ariz.
Schatz, W. R._____Ceres, Calif.
Schoenwetter, C. D.
_____Washington, D. C.
Shambaugh, G. E., III__Chicago, Ill.
Smith, A. L._____El Sereno, Calif.
Smith, P. H._____Falmouth, Mass.
Thranow, J. A._____La Belle, Fla.
Tobin, D. A._____Louisville, Ky.
Van Riper, H. E.___New York, N. Y.
Vergamini, J. C.__Great Falls, Mont.
Wax, R. E._____Escondido, Calif.
Werba, Daniel_____Phoenix, Ariz.
Wheeler, R. M.
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Wirka, H. W., Jr.
_____South Pasadena, Calif.
Zizic, T. M._____Baltimore, Md.

Members Serving in the Armed Forces

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Bryan, A. R._____APO New York 09742, N. Y.
Burg, R. M._____Randolph AFB, Tex.
Capozzi, Angelo_____Tiboron, Calif.
Chisholm, T. P._____Ft. Sam Houston, Tex.
Felton, O. L._____Wright Patterson AFB, Ohio
Fernando, O. U._____FPO San Francisco, Calif.
Gregorski, R. F._____San Antonio, Tex.
Harris, G. W._____Ft. McClellan, Ala.
Harris, R. C._____Wright Patterson AFB, Ohio
Helm, F. C._____FPO New York, N. Y.
Holzman, B. R._____APO San Francisco, Calif.
Ihle, C. V._____APO San Francisco, Calif.
Kinsey, J. L._____San Diego, Calif.
Maloney, J. D._____Ft. Collins, Colo.
Martens, T. J._____Pebble Beach, Calif.
McCabe, L. B._____Fort Jackson, S. C.
Meyer, G. A._____Galveston, Tex.
Nepomuceno, F. A._____Fort Hood, Tex.
Otterson, W. N._____Ft. Sam Houston, Tex.
Pellegrino, E. A., Jr._____Shepherd AFB, Tex.
Pettera, R. L._____Ft. Leavenworth, Kans.
Plotkin, Martin_____Maxwell AFB, Ala.
Schmidt, C. H._____APO San Francisco, Calif.
Schmidt, J. P._____Red Stone Arsenal, Ala.
Spence, C. H._____San Francisco, Calif.
Stilp, L. C., II_____Ft. Campbell, Ky.
Storms, W. W._____Ft. Carson, Colo.
Valaske, M. J._____Bethesda, Md.
Wagelie, R. W._____Fort Huachuca, Ariz.
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Hardman, H. F. ___Milwaukee, Wis.
Hunter, A. L. ___Green Valley, Ariz.
McCabe, John _____Austin, Tex.
McGill, James W. ____Superior, Wis.
Mortensen, O. A. ____Madison, Wis.
Morton, Silvanus A.
_____Beirut, Lebanon
Peterman, M. G. ___Milwaukee, Wis.
Pusey, W. A., Ph.D. ___Chicago, Ill.
Quick, A. J. _____Milwaukee, Wis.
Shideman, F. E. _Minneapolis, Minn.
Sisk, I. R. _____Madison, Wis.
Sullivan, W. E., Ph.D.
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Crumpacker, Margaret _____Kow Loon, Hong Kong
Feierabend, Theodore _____Ludhiana, Punjab, India
Grant, L. C. _____Nigeria, West Africa
Horning, J. S. _____Quito, Ecuador, South America
Jensen, Alfhild _____Puli, Taiwan
Morten, S. A. _____Beirut, Lebanon
Olsen, V. B. _____Chittagong, East Pakistan
Stinson, H. K. _____Madang, New Guinea

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Life Members

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Andrew, C. H. ----------Platteville
Barta, E. F. ----------Wauwatosa
Baum, E. L. ----------Naples, Fla.
Binnie, H. A. ----------Portage
Boren, C. H. ----------Marinette
Buckley, W. E. ----------Racine
Busse, A. A. ----------Jefferson
*Carlsson, E. S. ----------La Crosse
Carter, H. M. ----------Madison
Comstock, Elizabeth ---Neillsville
*Duer, G. R. ---Winter Haven, Fla.
Eck, G. E. ----------Lake Mills
Egan, W. J. ----------Milwaukee
Epley, O. H. -------New Richmond
Fitzgerald, R. E. -------Milwaukee

* Granted life membership in 1970.

*Foerster, H. R. --------Milwaukee
Franklin, Isadore ------Milwaukee
Gilchrist, R. T. --------Milwaukee
Graner, L. H. ----------Coleman
*Gundersen, Gunnar -----La Crosse
Heeb, H. J.
----Howey in the Hills, Florida
Hoffmann, J. G. ---------Hartford
Hoffmann, L. A. ----Campbellsport
Hogan, John H. ----------Racine
Jones, M. L. ----------Wausau
Judge, T. A. ----------Milwaukee
Keland, H. B. ----------Racine
Koch, H. C. ----------Berlin
Koch, M. J. ----------Milwaukee
Koehler, A. G. ----------Oshkosh
*Leahy, J. D. ----------Park Falls
Leonard, C. W. ------Fond du Lac
McCarey, A. J. ---------Green Bay
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Merten, A. N. E. -------Milwaukee
Middleton, W. S. ---------Madison
Moore, G. E. ----------Milwaukee
Nadeau, E. G. ----------Green Bay
Newman, J. R. ----------Madison
Ovitz, E. G. ----------Laona
Pleyte, A. A. ----------Milwaukee
Pope, F. W. ----------Racine
Randall, M. W.
---------Colorado Springs, Colo.
Robb, J. J. ----------Green Bay
Rose, J. F. ----------Lena
*Roth, W. C. ----------Racine
Schwartz, A. B. --------Milwaukee
Simons, N. S. ----------Whitehall
Sincock, H. A. ----------Superior
Stiennon, O. A. ----------Madison
Stovall, W. D. ----------Madison
Taylor, W. A. ----------Portage
Tharinger, E. L. -------Milwaukee
Towne, W. H. ---------Hortonville
Waldschmidt, W. J. --Fond du Lac

WISCONSIN PROGRAMS FOR PREVENTING AND TREATING NARCOTIC ADDICTION AND DRUG ABUSE: This information is available from the Division of Mental Hygiene, State Department of Health and Social Services, 1 West Wilson St., Madison, Wis. 53702; tel. (608) 266–1083.

NARCOTICS

Annual Registration

You must register with and pay tax to the District Director for the Internal Revenue District in which you propose to engage in any activity involving the use of narcotic drugs. For Wisconsin, the correct address is District Director, Internal Revenue Service, Post Office Building, Room 296, Milwaukee, Wisconsin 53202.

Change of Residence

Do not fail to notify the District Director, Milwaukee, Wisconsin, of any change of address. Failure to notify him within 30 days will make you subject to the tax, penalty and interest.

In Case of Death

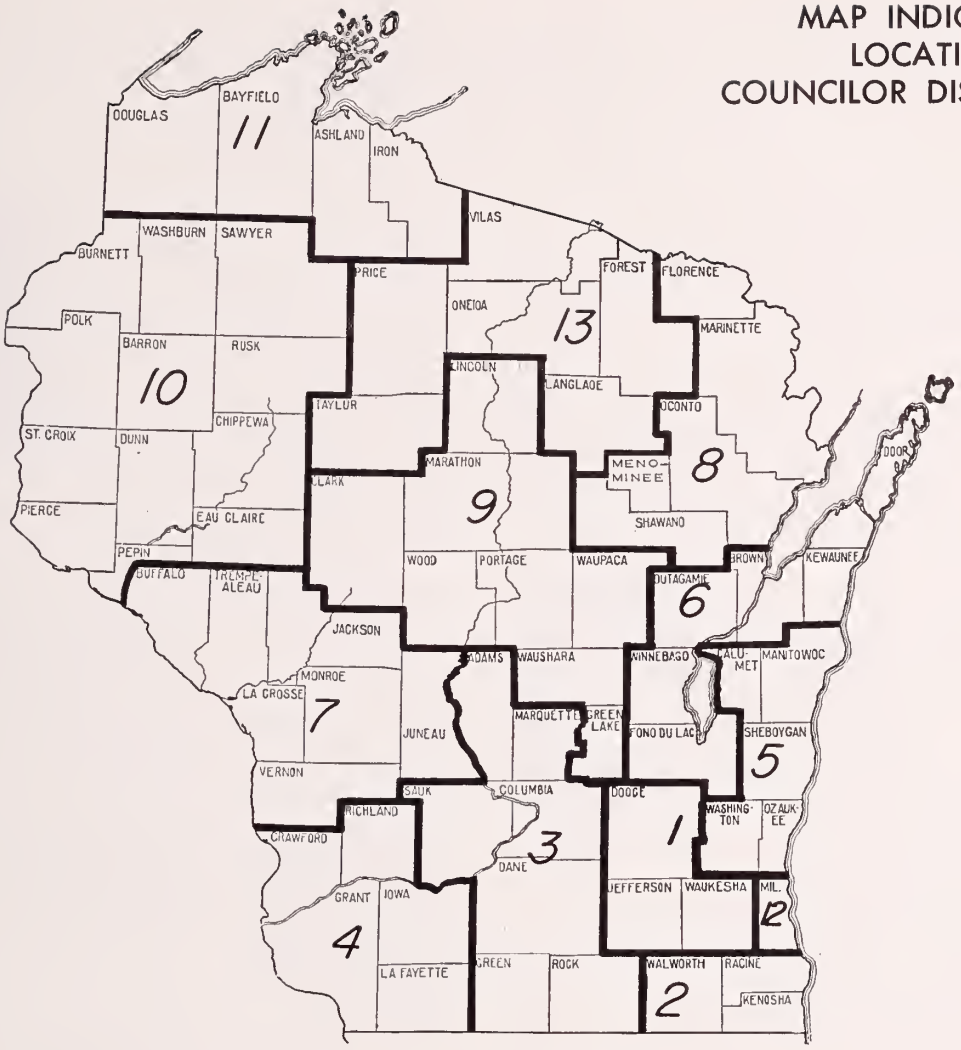
The Regional Director, Federal Bureau of Narcotics and Dangerous Drugs, Chicago, Illinois, who has jurisdiction over the State of Wisconsin with respect to these matters, approved the following procedure in a communication to the State Medical Society:

> "The deceased physician's Special Tax Stamp, unused Government order forms, and narcotic drugs should be disposed of as soon as possible. The Special Tax Stamp and unused Government order forms (Form 2513) should be returned to the District Director, Internal Revenue Service, Post Office Building, Milwaukee, Wisconsin 53202. The narcotic drugs may be disposed of by shipment, charges prepaid (shipment by registered mail is permissible) to the Regional Director, Bureau of Narcotics and Dangerous Drugs, Suite 1700, Engineering Building, 205 West Wacker Drive, Chicago, Illinois 60606, after the drugs have been inventoried on Forms 142, which can be obtained from the Regional Director. One copy of the Form 142 will be returned to the sender upon receipt of the narcotic drugs. No remuneration will be made for the narcotics surrendered to the Bureau of Narcotics and Dangerous Drugs."

Preprinted Prescription Blanks

The Justice Department, Federal Bureau of Narcotics and Dangerous Drugs, reports that neither Federal law nor administrative regulations prohibits the printing of the physician's narcotic registration number on prescription blanks.

MAP INDICATING LOCATION OF COUNCILOR DISTRICTS



Implied Consent

ANY PERSON OPERATING A MOTOR VEHICLE on the highways of the State of Wisconsin is deemed to have given consent to a test of his blood, breath, or urine to determine the alcohol content of his blood.

This law comes into operation only if the person is arrested and cited for driving under the influence of an intoxicant.

Refusal to submit to a test for blood alcohol under implied consent may lead to suspension of one's driver's license or a mandatory two-day imprisonment if convicted.

Under the law, only a physician or one acting under the direction of a physician may withdraw blood for the blood test, if used. The law provides immunity from liability, except for negligence, for persons drawing blood for implied consent testing.

The State Medical Society of Wisconsin has prepared guidelines for physicians in connection with their responsibilities under the implied consent law. These guidelines and a copy of the consent form may be obtained upon request to the State Medical Society of Wisconsin, Box 1109, Madison, Wisconsin 53701, or telephone 608/257–6781.

Officers and Councilors 1970-1971

State Medical Society of Wisconsin

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1011 North Eighth St., Sheboygan 53081

PRESIDENT-ELECT (1970–1971) .....**G. A. Behnke, MD**
1015 West Wisconsin Ave., Kaukauna 54130

SECRETARY .....**E. R. Thayer**
330 East Lakeside St., Madison 53701

TREASURER (1970–1971) .....**F. L. Weston, MD**
1659 Sherman Ave., Madison 53704

SPEAKER (1969–1971) .....**T. J. Nereim, MD**
P.O. Box 65, Mt. Horeb 53572

VICE-SPEAKER (1970–1971) .....**W. D. Hamlin, MD**
Mineral Point 53565

PAST PRESIDENT (1970–1971) ....**Robert E. Callan, MD**
1733 West Wisconsin Ave., Milwaukee 53233

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E. J. Nordby, MD, Madison, Chairman

J. M. Sullivan, MD, Milwaukee, Vice-chairman

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Second: Kenosha, Racine, and Walworth County Societies. **R. S. Galgano, MD** (1969–1972), 610 Walworth Ave., Delavan 53115.

Third: Dane, Columbia–Marquette–Adams, Green, Rock, and Sauk County Societies. **E. J. Nordby, MD** (1970–1973), 2715 Marshall Ct., Madison 53705; **M. F. Huth, MD** (1968–1971), 203 Fourth St., Baraboo; **Gordon Davenport, Jr., MD** (1969–1972), 20 South Park St., Madison 53715.

Fourth: Crawford, Grant, Iowa, Lafayette, and Richland County Societies. **R. W. Edwards, MD** (1970–1973), 1313 W. Seminary St., Richland Center 53581.

Fifth: Calumet, Manitowoc, Sheboygan, Washington, and Ozaukee County Societies. **W. F. Smejkal, MD** (1970–1973), Manitowoc 54220.

Sixth: Brown, Door–Kewaunee, Fond du Lac, Outagamie, and Winnebago County Societies. **Howard Mauthe, MD** (1970–1973), 3802 DeNeveu Lane, Fond du Lac 54935; **J. E. Dettmann, MD** (1968–1971), 519 South Monroe Ave., Green Bay 53401.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo, and Vernon County Societies. **E. P. Rohde, MD** (1968–1971), Galesville 54630.

Eighth: Marinette–Florence, Oconto, and Shawano County Societies. **J. W. Boren, Jr., MD** (1968–1971), 1510 Main St., Marinette 54143.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca, and Wood County Societies. **E. P. Ludwig, MD** (1968–1971), Route 2, Box 124, Wild Rose 54984.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk, and Rusk County Societies. **W. R. Manz, MD** (1968–1971), 204 East Grand Ave., Eau Claire 54701.

Eleventh: Ashland–Bayfield–Iron, and Douglas County Societies. **T. J. Doyle, MD** (1969–1972), 1507 Tower Ave., Superior 54880.

Twelfth: The Medical Society of Milwaukee County. **T. J. Foley, MD** (1969–1972), 3316 West Wisconsin Ave., Milwaukee 53208; **D. K. Schmidt, MD** (1970–1972), 330 W. Silver Spring Drive, Milwaukee 53217; **W. J. Egan, MD** (1970–1973), 525 East Wells St., Milwaukee 53202; **S. L. Chojnacki, MD** (1968–1971), 3122 South Thirteenth St., Milwaukee 53215; **S. W. Hollenbeck, MD** (1968–1971), 2650 West Fond du Lac Ave., Milwaukee 53206; **J. M. Sullivan, MD** (1970–1973), 161 West Wisconsin Ave., Milwaukee 53203.

Thirteenth: Forest, Langlade, Oneida–Vilas, and Price–Taylor County Societies. **Marvin Wright, MD** (1968–1971), 1020 Kabel Ave., Rhinelander 54501.

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President McRoberts

Speaker Nereim

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J. M. Bell, MD (1971–1972), 516 Houston St., Marinette 54143.

G. E. Collentine, Jr., MD (1971–1972), 2266 North Prospect Ave., Milwaukee 53202.

C. J. Picard, MD (1971–1972), 425 Twenty-first Ave., East, Superior 54880.

Alternates

W. T. Russell, MD (1970–1971), 114 Columbus St., Sun Prairie 53590.

H. F. Twelmeyer, MD (1971), 2500 N. Mayfair Rd., Wauwatosa 53226

J. C. Fox, MD (1971–1972), 212 South Eleventh St., La Crosse 54601.

D. J. Carlson, MD (1971–1972), 2320 North Lake Dr., Milwaukee 53211

H. J. Kief, MD (1971–1972), 505 East Division St., Fond du Lac 54935

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* Map indicating location of councilor districts, page 59.

Note: Officers, councilors, delegates, and members of Standing Committees are elected at the Annual Meeting in May. Dates in parentheses indicate beginning and expiration of term of office.

Standing Committees—1970-1971

State Medical Society of Wisconsin

COMMITTEE ON CANCER

(Composed of a member from each Councilor District)

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J. J. Gramling, Jr., MD (1968–1971) ... Milwaukee 53202
Chairman 10425 West North Ave.

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107 North Third St.

Helen J. Gurkow, MD (1968–1971) ... Platteville 53818
195 East Main St.

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1605 Monroe St.

G. H. Williams, MD (1970–1973) ..... Marshfield 54449
650 South Central Ave.

G. I. Uhrich, MD (1968–1971) ..... La Crosse 54601
212 South Eleventh St.

R. C. Frank, MD (1968–1971) ..... Eau Claire 54701
Sacred Heart Hospital

J. F. Brown, MD (1968–1971) ..... Rhinelander 54501
1020 Kabel Ave.

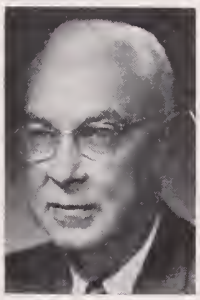
J. R. Hoon, MD (1969–1972) ..... Sheboygan 53081
1011 North 8th St.

G. Daniel Miller, MD (1969–1972) .. Oconomowoc 53066
37880 Forrest Dr.

F. L. Schaefer, MD (1969–1972) ..... Neenah 54956
1416 South Commercial St.

D. A. Jeffries, MD (1970–1973) ..... Shawano 54166
Cantwell–Peterson Clinic

C. M. Scott, MD (1969–1972) ..... Superior 54880
318 21st Avenue East



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E. W. Mason, MD (1968–1971) ..... Milwaukee 53202
Chairman 324 East Wisconsin Ave.

C. E. Wall, MD (1970–1973) ..... Manitowoc 54220
904A South Eighth St.

O. G. Moland, MD (1970–1973) ..... Augusta 54722

E. D. Sorenson, MD (1968–1971) ..... Elkhorn 53121
104 South Wisconsin St.

R. W. Mason, MD (1968–1971) ..... Marshfield 54449
650 South Central Ave.

D. R. Griffith (1969–1972) ..... Eau Claire 54701
314 Grand Ave. East

M. F. Huth, MD (1969–1972) ..... Baraboo 53913
203 Fourth St.

O. E. Larson, MD (1970–1973) ..... Neenah 54956
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905 University Ave.

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8700 West Wisconsin Ave.

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5001 Monona Dr.

E. R. Daniels, MD (1967–1972) ..... Wauwatosa 53213
7400 Harwood Ave.

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1300 University Ave.

Richard Wasserburger, MD (1969–1974) . Madison 53705
2500 Overlook Terrace

V. S. Falk, Jr., MD., Medical Editor, *Wisconsin Medical Journal* ..... Edgerton 53534
Ex officio 5 West Rollin St.

G. A. Kerrigan, MD, Dean, The Medical College of Wisconsin ..... Milwaukee 53233
Ex officio 561 North 15th St.

P. L. Eichman, MD, Dean, University of Wisconsin Medical School ..... Madison 53706
Ex officio 1300 University Ave.

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Chairman 2243 North Prospect Ave.

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W. C. Harris, MD (1968–1971) ..... Racine 53404
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R. G. Hansel, MD (1968–1971) ..... Baraboo 53913
407 Oak St.

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300 Femrite Dr.

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505 East Division St.

P. E. Wainscott, MD (1970–1973) ..... Menasha 54952
422 Broad St.

Vacancy

Committee on Occupational Health

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Chairman 2108—63rd St.

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300 Femrite Dr.

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808 Third St.

O. T. Mallery, MD ..... Wausau 54401
2000 Westwood Dr.

Carl Zenz, MD ..... West Allis 53214
1126 S. 70th St.

A. G. Brailey, MD ..... La Crosse 54601
1836 South Ave.

W. W. Ford, MD ..... Green Bay 54301
700 E. Walnut St.

D. M. Rowe, MD ..... Kohler 53044

W. A. Nielsen, MD ..... West Bend 53095
P. O. Box 379

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It is your opportunity to give financial assistance to the charitable, educational and scientific aspects of medicine as they relate to the health and well-being of the people of Wisconsin. All contributions to the Foundation are deductible for income tax purposes. Checks may be made out to: CES Foundation, and sent to CES Foundation, State Medical Society of Wisconsin, Box 1109, Madison, Wis. 53701.

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Chairman 114 Columbus St.

C. F. Broderick, MD (1968–1973) .. Wisconsin Dells 53965
Vice-chairman Box 325

E. C. Quackenbush, MD (1967–1972) .... Hartford 53027
14 North Main St.

L. W. Schrank, MD (1967–1972) .....Waupun 53963
600 Fern St.

T. E. Henney, MD (1967–1972) ..... Portage 53901
310 West Conant St.

J. M. Lubitz, MD (1969–1974) ..... Brookfield 53005
16350 Alverno Dr.

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2405 Northwestern Ave.

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William Kreul, MD (1970–1973) ..... Racine 53403
Anesthesiology 100—12th St.

H. A. Peters, MD (1970–1973) ..... Madison 53706
Neurology & Psychiatry 1300 University Ave.

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Ophthalmology 1620 N. Meade St.

P. A. Sciarra, MD (1970–1973) ..... Sheboygan 53081
Otolaryngology 1011 North Eighth St.

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Pediatrics 2020 E. Milwaukee St.

R. L. Gilbert, MD (1968–1971) ..... La Crosse 54601
Internal Medicine 815 S. 10th St.

J. C. Fralich, MD (1968–1971) ..... Racine 53404
Obstetrics & Gynecology 2405 Northwestern Ave.

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Orthopedics 20 S. Park St.

J. G. Frisch, MD (1968–1971) ..... Milwaukee 53211
Urology 2613 E. Shorewood Blvd.

Wayne Boulanger, MD (1968–1971) .. Milwaukee 53202
Surgery 425 E. Wisconsin Ave.

T. M. Thorgersen, MD (1969–1972) .. Waukesha 53186
Pathology 715 Tenny Ave.

J. R. McKenzie, MD (1969–1972) ..... Oshkosh 54901
Radiology 415 South Meadow

Roger Laubenheimer, MD (1969–1972) . Milwaukee 53202
Dermatology 425 East Wisconsin Ave.

N. G. Bauch, MD (1969–1972) ..... Milwaukee 53222
General Practice 3102 North 78th St.

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A person subject to epileptic seizures may be licensed to drive a motor vehicle in Wisconsin on a temporary basis if:

(1) He submits with his application a certificate from a licensed physician recommending that a temporary driver's license be issued, and
(2) He is otherwise qualified to obtain a license.

The certificate is a form prepared by the Division of Motor Vehicles and is designed to elicit medical information necessary to determine whether permitting the epileptic to drive would be a hazard to public safety.

To retain his license the epileptic must present a new certificate every six months.

The issuance of a temporary license is discretionary with the Division of Motor Vehicles. A denial may be reviewed, however, by a special board.

Reference: Section 343.09, Wisconsin Statutes.

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Douglas	Clarence M. Scott 318—21st Ave. East Superior 54880	Sviatoslav N. Riabov 312 E. 7th St. Superior 54880
Eau Claire–Dunn–Pepin	Harry E. Thimke 3746 Patton St. Eau Claire 54701	Verne A. Sperry 715 S. Barstow Eau Claire 54701
Fond du Lac	George F. Meisinger Route 3, Box 233C Fond du Lac 54935 *Treasurer:* E. Howard Theis 92 E. Division St. Fond du Lac 54935	Joseph C. Devine 105 Sheboygan Ave. Fond du Lac 54935
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Iowa	S. B. Marshall Hollandale 53544	H. P. Breier Montfort 53569

Find your future in the HEALTH FIELD

. . . a career guide

"Find your future in the health field," urges a brochure published by the Wisconsin Health Council, Inc. The brochure, developed with the assistance of the State Medical Society, contains information on 26 careers in health.

The publication is unique in its presentation. It is intended to supplement existing careers materials, and gives factual and statistical information on personal qualifications, educational requirements and opportunities, and employment possibilities in each of the fields. It places emphasis on Wisconsin.

Copies are distributed to guidance counselors in every Wisconsin school, and individual copies are available from the Wisconsin Health Council to youngsters interested in health careers.

Supplies are also available to physicians who participate in career days in their local schools; they may be obtained by writing the State Medical Society, Box 1109, Madison 53701.

The Wisconsin Health Council, which published the brochure, was formed in 1948 to stimulate citizen interest in public health in Wisconsin.

County Medical Society	President	Secretary
Jefferson	Eugene P. Schuh 1507 Doctors Ct. Watertown 53094	Donald E. Bates 311 S. Main St. Ft. Atkinson 53538
Juneau	Jack Strong Mauston 53948	Clayton Weston New Lisbon 53950
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Marathon	Charles M. Balliet 400 Strollers Lane Wausau 54401	Curt G. Grauer 614 N. 3rd Ave. Wausau 54401
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Trempealeau–Jackson–Buffalo		Eugene Krohn 221 Main St. Black River Falls 54615
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Wood	N. W. Arendt 184 2nd St. N. Wis. Rapids 54494	Francis Kruse, Jr. 630 S. Central Ave. Marshfield 54449

Recipients of the Council Award

Established in 1929, the Council Award represents the highest award in the power of the State Medical Society to bestow upon one of its members or, at times, on one closely connected with the work of the profession in the state. It is granted only upon occasion. It is granted only by unanimous vote of the Council. It is granted only to such as have served with outstanding distinction the science of medicine, their fellow physicians, and the public.

Of those who have been its recipients, it may truly be said that they have personified the highest traditions of medicine in their devotion to the public good.

John M. Dodd, MD† 1930
Cornelius A. Harper, MD† 1930
John J. McGovern, MD† 1931
Louis M. Jermain, MD† 1931
Edward Evans, MD† 1931
Mina B. Glasier, MD† 1932
Arthur W. Rogers, MD† 1934
Rock Sleyster, MD† 1934
Olin West, MD† 1934
Edward A. Birge, PhD† 1935
Arthur J. Patek, MD† 1935
Joseph F. Smith, MD† 1937
Eben J. Carey, MD† 1938
William S. Middleton, MD 1938
Fred G. Johnson, MD† 1939
William D. Stovall, MD 1940
Ludvig Hektoen, MD*† 1941
Stephen E. Gavin, MD† 1944
F. Gregory Connell, MD† 1947
E. R. Schmidt, MD† 1949
Armand J. Quick, MD 1950
F. A. Stratton, MD† 1951
Gunnar Gundersen, MD 1953
W. J. Meek, PhD† 1953
R. G. Arveson, MD† 1957
Edwin B. Fred, PhD 1958
Harry Beckman, MD 1959
Elizabeth Comstock, MD 1961
Harry Steenbock, PhD† 1963
Francis J. L. Blasingame, MD 1964
C. N. Neupert, MD† 1965
Spencer D. Beebe, MD† 1965
Frank L. Weston, MD** 1966
Robert E. Fitzgerald, MD** 1966
William B. Walsh, MD 1967
H. Kent Tenney, MD 1969

* Centennial Award. † Deceased.
** 125th Anniversary Award.

Recipients of the Presidential Citation

The President of the State Medical Society, with the unanimous approval of the Council, has the privilege of presenting a Presidential Citation to a non-physician who has made a significant contribution to medicine or public health.

Since the establishment of this citation in 1959, the following persons have been so recognized:

Reuben Knutson (Chairman, Wisconsin Industrial Commission) 1959
Helen Crawford (Librarian, University of Wisconsin Medical School Library) 1962
The Rev. Edward J. O'Donnell, S. J. (Chancellor of Marquette University) 1963
Harvey Higley (Former Administrator of Veterans Affairs), Marinette 1965
Francis J. Wilcox (National Board Chairman, American Cancer Society, and Board of Directors, Wisconsin Division, ACS), Eau Claire 1966
Warren P. Knowles (Governor of the State of Wisconsin), Madison 1967
Leo C. Massopust (Scientific photographer, artist, and editor), Milwaukee 1968
Karl F. Schmidt, PhD (Associate Director for Radio [WHA] at University of Wisconsin), Madison .. 1969
The Most Rev. Father Carl Mansfeld, Milwaukee.. 1970

Compilation of Articles on: *The Best of Law and Medicine*

"The Best of Law and Medicine," a compilation of articles appearing in *JAMA* during the period January, 1966, through February, 1968, has been introduced to help familiarize physicians with legal situations with which they may be confronted in their practice.

This collection deals with particular aspects of the impact of law upon the practice of medicine. Demand for reprints of the individual articles became so great that the AMA Committee on Medicolegal Problems suggested that a publication containing the most popular items be produced. The Legal Research Department of the AMA Law Division, which is responsible for content, selected the articles it felt would provide both interesting and useful reference sources for physicians, as well as others interested in this aspect of the law.

Medical liability, medical health and medical evidence represent only a few of the eight major categories covered by the handbook. The 8½"x11", 184-page paperback is *not* intended as a do-it-yourself law book for physicians, nor is it to be considered a substitute for personal legal advice from an attorney.

Residents in the U.S., U.S. Possessions, Canada and Mexico may secure a copy for $1.50. Medical students, hospital interns and residents in these areas may receive it for only 75¢. The price in all other countries is $1.75. Orders should be coded "OP-179" and directed to the American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

Past Presidents of the State Medical Society

Mason C. Darling, M.D., Fond du Lac.....1841–1847
John B. Dousman, M.D., Milwaukee.....1847–1849
Alfred L. Castleman, M.D., Delafield.....1849–1851
Harmon Van Dusen, M.D., Mineral Point...1851–1854
Alfred L. Castleman, M.D., Delafield.....1854–1855
John Mitchell, M.D., Janesville.....1855–1856
David Cooper Ayres, M.D., Green Bay.....1856–1857
Clark G. Pease, M.D., Janesville.....1857–1859
Ezra S. Carr, M.D., Madison.....1859–1861
Solomon Blood, M.D., Rochester.....1861–1862

(No meetings held from 1863 through 1866; apparently no new officers).

Harmon Van Dusen, M.D., Mineral Point....1867–1869
Solon Marks, M.D., Milwaukee.....1869–1870
Henry P. Strong, M.D., Beloit 1870–1871
John Favill, M.D., Madison.....1871–1872
Harmon Van Dusen, M.D., Mineral Point....1872–1873
Marvin Waterhouse, M.D., Portage.....1873–1874
James T. Reeve, M.D., Appleton.....1874–1875
Joseph B. Whiting, M.D., Janesville.....1875–1876
John K. Bartlett, M.D., Milwaukee.....1876–1877
Darius Mason, M.D., Prairie du Chien.....1877–1878
Nicholas Senn, M.D., Milwaukee.....1878–1879
John G. Meachem, Sr., M.D., Racine.....1879–1880
Ira Manley, Jr., M.D., Markesan.....1880–1881
William Meacher, M.D., Portage.....1881–1882
Thomas P. Russell, M.D., Oshkosh.....1882–1883
Nelson M. Dodson, M.D., Berlin.....1883–1884
Edwin W. Bartlett, M.D., Milwaukee.....1884–1885
G. M. Steele, M.D., Oshkosh.....1885–1886
Samuel C. Johnson, M.D., Hudson.....1886–1887
Leroy G. Armstrong, M.D., Boscobel.....1887–1888
John R. Barnett, M.D., Neenah.....1888–1889
Ezra M. Rogers, M.D., Hartford.....1889–1890
George D. Ladd, M.D., Milwaukee.....1890–1891
George F. Witter, M.D., Grand Rapids
(Wisconsin Rapids).....1891–1892
Benjamin T. Phillips, M.D., Menominee, Mich..1892–1893
Benjamin C. Brett, M.D., Green Bay.....1893–1894
Almon Clarke, M.D., Sheboygan.....1894–1895
Frank W. Epley, M.D., New Richmond.....1895–1896
B. O. Reynolds, M.D., Lake Geneva.....1896–1897
William Mackie, M.D., Milwaukee.....1897–1898
Herman Reineking, M.D., Milwaukee.....1898–1899
Wilbur T. Sarles, M.D., Sparta.....1899–1900
John F. Pritchard, M.D., Manitowoc.....1900–1901
Walter H. Neilson, M.D., Milwaukee.....1901–1902
John V. R. Lyman, M.D., Eau Claire.....1902–1903
Franklin E. Walbridge, M.D., Milwaukee.....1903–1904
Charles W. Oviatt, M.D., Oshkosh.....1904–1905
John R. Currens, M.D., Two Rivers.....1905–1906
Levi H. Pelton, M.D., Waupaca.....1906–1907
William E. Ground, M.D., Superior.....1907–1908
Gilbert E. Seaman, M.D., Madison.....1908–1909
Edward Evans, M.D., La Crosse.....1909–1910
Byron M. Caples, M.D., Waukesha.....1910–1911
John M. Dodd, M.D., Ashland.....1911–1912
Arthur J. Patek, M.D., Milwaukee.....1912–1913
Charles S. Sheldon, M.D., Madison.....1913–1914
Theodore J. Redelings, M.D., Marinette.....1914–1915
Louis J. Jermain, M.D., Milwaukee.....1915–1916
Hoyt E. Dearholt, M.D., Milwaukee.....1916–1917
Gustave Windesheim, M.D., Kenosha.....1917–1918
Dennis J. Hayes, M.D., Milwaukee.....1918–1919
Charles R. Bardeen, M.D., Madison.....1919–1920
Henry W. Abraham, M.D., Appleton*.....1920
Matthew A. McGarty, M.D., La Crosse.....1920–1921
Sidney Hall, M.D., Ripon.....1921–1922
F. Gregory Connell, M.D., Oshkosh.....1922–1923
Rock Sleyster, M.D., Wauwatosa.....1923–1924
Wilson Cunningham, M.D., Platteville.....1924–1925
Joseph F. Smith, M.D., Wausau.....1925–1926
Arthur W. Rogers, M.D., Oconomowoc.....1926–1927
John J. McGovern, M.D., Milwaukee.....1927–1928
Karl W. Doege, M.D., Marshfield.....1928–1929
Frederick J. Gaenslen, M.D., Milwaukee.....1929–1930
A. J. McDowell, M.D., Soldiers Grove†.....1930
Cornelius A. Harper, M.D., Madison.....1930–1931
Otho Fiedler, M.D., Sheboygan.....1931–1932
Reginald H. Jackson, M.D., Madison.....1932–1933
Stanley J. Seeger, M.D., Milwaukee.....1933–1934
Thomas J. O'Leary, M.D., Superior.....1934–1935
Ralph M. Carter, M.D., Green Bay.....1935–1936
Stephen E. Gavin, M.D., Fond du Lac.....1936–1937
James C. Sargent, M.D., Milwaukee.....1937–1938
Albert E. Rector, M.D., Appleton.....1938–1939
Raymond G. Arveson, M.D., Frederic.....1939–1940
Ralph P. Sproule, M.D., Milwaukee.....1940–1941
Gunnar Gundersen, M.D., La Crosse.....1941–1942
Francis E. Butler, M.D., Menomonie.....1942–1943
Russell M. Kurten, M.D., Racine.....1943–1944
Charles Fidler, M.D., Milwaukee.....1944–1945
P. R. Minahan, M.D., Green Bay.....1945–1946
Charles A. Dawson, M.D., River Falls.....1946–1947
William D. Stovall, M.D., Madison.....1947–1948
Karl H. Doege, M.D., Marshfield 1948–1949
John W. Truitt, M.D., Milwaukee.....1949–1950
Henry H. Christofferson, M.D., Colby.....1950–1951
Albian H. Heidner, M.D., West Bend.....1951–1952
Joseph C. Griffith, M.D., Milwaukee.....1952–1953
H. Kent Tenney, M.D., Madison.....1953–1954
Arthur J. McCarey, M.D., Green Bay‡.....1954–1955
Ervin L. Bernhart, M.D., Milwaukee.....1955–1956
L. O. Simenstad, M.D., Osceola.....1956–1957
Harry E. Kasten, M.D., Beloit.....1957–1958
Jerome W. Fons, M.D., Milwaukee.....1958
William B. Hildebrand, M.D., Menasha.....1959–1960
Edmund D. Sorenson, M.D., Elkhorn.....1960–1961
Leif H. Lokvam, M.D., Kenosha.....1961–1962
Nels A. Hill, M.D., Madison.....1962–1963
William J. Egan, M.D., Milwaukee.....1963–1964
William P. Curran, M.D., Antigo.....1964–1965
J. H. Houghton, M.D., Wisconsin Dells.....1965–1966
Frank E. Drew, M.D., Milwaukee.....1966–1967
H. J. Kief, MD, Fond du Lac.....1967–1968
W. D. James, MD, Oconomowoc 1968–1969
Robert E. Callan, MD, Milwaukee 1969–1970

* *Died during term of office as president-elect.*

† *Resigned, because of health, prior to taking office.*

‡ *Through April, 1955. The date of the Society's Annual Meeting, at which the president is elected, was changed from October to May during this year.*

Department of Health and Social Services

ADDRESS: 1 West Wilson St., Madison, Wis. 53702 TELEPHONE: (608) 266–3681

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continued on next page

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No. 2—9618 West Greenfield Ave.; Phone 224–4486 ..... West Allis
No. 3—485 South Military Rd.; P.O. Box 269; Phone 922–1290 ..... Fond du Lac
No. 4—Room 612, City Hall, 100 North Jefferson St.; P. O. Box 98;
Phone 437–8727 ..... Green Bay
No. 5—District State Office Building, 250 Mormon Coulee Rd.; Phone 784–0700 .. La Crosse
No. 6—Eau Claire State Office Building, 718 West Clairemont Ave;
Phone 834–2931 ..... Eau Claire
No. 7—District State Office Building, 1681 Second Ave. South, P. O. Box 270;
Phone 423–4730 ..... Wisconsin Rapids
Schiek Plaza, P. O. Box 697; Phone 362–7800 ..... Rhinelander

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J. Jack Harned, DO (July 1, 1975)	2710 Marshall Court Madison 53705	(608) 238–9711
L. C. Scribner, DDS (July 1, 1977)	1039 A Main Street Stevens Point 54481	(715) 344–2696

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Kenneth McClarnon, Assistant Director	Bureau of Operations	266–2168
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Robert Sandahl, Supervisor	Social Security Trust Fund Section	266–3729
John Dunn	Public Information Officer	266–3386
Vincent Scallon	Accountant	266–3956
John Funseth	Systems Analyst	266–2380
Gary West	Accountant	266–2649
Gerhardt Heil	Accountant	266–2649

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Alfred R. Meier, Director; tel. 266–1565

BUREAU FOR THE BLIND, 5316 West State St., Milwaukee 53208; tel. (414) 771–5311
E. Leonard Hoskins, Director; tel. 771–5311

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Laurence E. Opheim, District Supervisor

FOND DU LAC DISTRICT: 20 Forest Ave., Fond du Lac 54935; tel. (414) 921–5883
James A. Mather, District Supervisor

Oshkosh Local Office: 424 Washington Ave., Oshkosh 54901; tel. (414) 231–5220
Paul Monzel, Rehabilitation Supervisor

Sheboygan Local Office: 832 Niagara Ave., Sheboygan 53081; tel. (414) 458–8361
George J. Herrmann, Rehabilitation Supervisor

GREEN BAY DISTRICT: 1142 Main St., Green Bay 54301; tel. (414) 432–8691
Roger M. Siegworth, District Supervisor

LA CROSSE DISTRICT: State Office Building, Mormon Coulee Road, La Crosse 54601; tel. (608) 788–2500
John P. Purcell, District Supervisor

MADISON DISTRICT: 137 East Wilson St., Madison 53703; tel. (608) 266–3655
Rodney R. Van Deventer, District Supervisor; tel. (608) 266–3543

Janesville Local Office: 101 South Main St., Janesville 53545; tel. (608) 754–2861
Wayne Olson, Rehabilitation Supervisor

Mendota State Hospital: 301 Troy Dr., Madison, 53704; tel. (608) 244–2411, ext. 232 or 236
Paul Rasmussen, Rehabilitation Supervisor

University Counseling: 1800 University Ave., Madison 53706; tel. (608) 266–3926
Patrick Mommaerts, Rehabilitation Supervisor

MILWAUKEE DISTRICT: 819 North 6th St., Milwaukee 53203; tel. (414) 224–4677
William R. Newberry, District Supervisor

Milwaukee County Mental Health Center, 9035 Watertown Plank Rd., Milwaukee 53226; tel. (414) 258–2040, ext. 3161
Janice Petrus, Rehabilitation Supervisor

RHINELANDER DISTRICT: P.O. Box 697, Schiek Plaza, Rhinelander 54501; tel. (715) 362–7800
Roy C. Huser, District Supervisor

SUPERIOR DISTRICT: 917 Tower Ave., Superior 54880; tel. (715) 392–8171
LeRoy R. Forslund, District Supervisor

WAUKESHA DISTRICT: 148 Wisconsin Ave., Waukesha 53186; tel. (414) 542–9414
Kenneth F. Krumnow, District Supervisor

Racine Local Office: 5200 Washington Ave., Racine 53403; tel. (414) 637–9165
Raymond F. Truesdell, Rehabilitation Supervisor

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REFERENCE GUIDE—"TOMORROW WITHOUT TB"

A new booklet, designed to stimulate active participation in the effort to eradicate tuberculosis, is currently receiving widespread distribution throughout the United States.

Produced by Lederle Laboratories, a Division of American Cyanamid Company, the 20-page booklet is entitled "Tomorrow Without TB."

The publication offers "a working plan to help eradicate tuberculosis" and highlights the importance of tuberculin testing of all school children. A special appendix provides information on school tuberculosis testing regulations and/or recommendations for the 50 states. The booklet also gives background information concerning the disease itself and facts about the overall nationwide program for its eradication.

"Tomorrow Without TB" is being made available to state and school health officers, medical societies, the national headquarters of various civic organizations and state and local tuberculosis associations.

The booklet was prepared by the Trade Information Services Department at Lederle Laboratories, Pearl River, N. Y. 10965. Single copies are available upon request.

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Diabetic Pregnancy and Fetal Outcome

Comparison of Recent and Earlier Results in the Same Hospital

By Francis N. Lohrenz, MD,
Thomas F. Nikolai, MD,
and James R. Heersma, MD
Marshfield, Wisconsin

Diabetic pregnancies at the St. Joseph's Hospital during a 20-year period, 1938–1957, and during a 10-year period, 1958–1967, are reviewed. Progress in management of the diabetic pregnancies has been demonstrated by an increase in the total viability rate in infants of diabetic mothers. A most significant finding was a decrease in the neonatal death rate from 13% to 1.2%. Close diabetic control of the mother and a team approach by the obstetrician, internist, and pediatrician are significant factors in this improvement.

WE HAVE CONFIRMED that close cooperation between obstetrician, internist-diabetologist, and pediatrician will improve the outcome of diabetic pregnancy. A concerted team approach has reduced the number of neonatal deaths, thereby increasing the number of surviving infants. There were no maternal deaths in our latest series of patients.

Our conclusions were reached by comparing records of St. Joseph's Hospital for the years 1958 through 1967 with records from the same hospital for the years 1938 through 1957. The earlier records were the subject of a 1959 report by Baldwin, *et al*[1] who reviewed 91 pregnancies in 46 diabetic women. This new study from the same physician-hospital group reports results of 78 diabetic pregnancies in 50 diabetic women.

From St. Joseph's Hospital, the Marshfield Clinic, and Marshfield Clinic Foundation for Medical Research and Education.

Doctors Lohrenz and Nikolai are from the Section of Endocrinology, and Doctor Heersma is from the Department of Pediatrics, all of the Marshfield Clinic.

Reprint requests to: Francis N. Lohrenz, MD, 650 South Central Ave., Marshfield, Wis. 54449.

TABLE 1—*Annual Results of ALL Diabetic Pregnancies. Data from St. Joseph's Hospital 1958 through 1967.*

Year	Surviving Infants	Still-births	Abortions	Neonatal Deaths	Total Pregnancies
1958	5	1	2	0	8
1959	1	2	4	1	8
1960	3	2	0	0	5
1961	7	1	2	0	10
1962	7	0	3	0	10
1963	5	0	2	0	7
1964	2	2	0	0	4
1965	9	0	0	0	9
1966	8	0	1	0	9
1967	5	1	2	0	8
TOTALS	52	9	16	1	78

Method and Criteria. We reviewed the charts of all pregnant women admitted to St. Joseph's Hospital, Marshfield, Wisconsin, during the years 1958 through 1967 with a diagnosis of diabetes mellitus. We also reviewed the charts of all infants born to these women and evaluated neonatal outcome.

Abortion was defined as spontaneous delivery of a fetus before 12 to 14 weeks of gestation, *stillbirth* as death *in utero* after 12 to 14 weeks of gestation, *perinatal death* as infant death less than 5 days after birth, and *neonatal death* as infant death between 5 and 30 days after birth.

With one modification, we used White's criteria[2,3] to grade severity of diabetes as follows:

Class A: borderline (chemical) diabetes requireing no insulin but excluding "gestational diabetes" (normal glucose tolerance test three to four months post partum).

Class B: onset of diabetes past age 20, duration less than 10 years, and absence of vascular lesions.

Class C: onset between ages 10 and 19 years, duration from 10 to 19 years, and absence of vascular lesions.

Class D: retinopathy or calcified leg arteries regardless of onset or duration of diabetes, or onset before age 10 years, or diabetes exceeding 20 years of duration.

Diabetic control, mainly the patient's own regulation of her diabetes, was classified as follows:

Excellent regulation: six to eight monthly prenatal visits to obstetrician and internist beginning with first knowledge of pregnancy; postprandial blood sugar consistently 150 mg or less per 100 ml; and glycosuria in less than 20% of voidings.

TABLE 2—*Results of ALL Diabetic Pregnancies. Earlier and later studies at St. Joseph's Hospital.*

Years	Total Pregnancies	Spontaneous Abortions	Viable Pregnancies*	Stillbirths	Neonatal Deaths	Fetal Loss**	Surviving Infants
1938–1957	91	17 (18.7%)	74 (81.3%)	9 (9.9%)	12 (13.2%)	38 (41.8%)	53 (58.2%)
1958–1967	78	16 (20.5%)	62 (79.5%)	9 (11.5%)	1 (1.3%)	26 (33.3%)	52 (66.7%)

*Total pregnancies minus abortions.
**Abortions plus stillbirths plus neonatal deaths.
All percentages based on total pregnancies.

Good regulation: four to five prenatal visits to obstetrician and internist; postprandial blood sugar consistently 180 mg or less per 100 ml; and glycosuria in less than 50% of voidings.

Poor regulation: fewer than four prenatal visits; postprandial blood sugar consistently greater than 180 mg per 100 ml; and persistent glycosuria in voidings during office visits, before and after each meal, and at bedtime.

Results. Table 1 lists the annual number of diabetic pregnancies and their results classified by surviving infants, stillbirths, abortions, and neonatal deaths. There has been no neonatal death since 1959.

Table 2 compares the results of diabetic pregnancies during the 10 years, 1958 through 1967, with results during the 20 years, 1938 through 1957. The most obvious difference is a marked decrease of neonatal deaths from 13% in the earlier study to 1. 3% in the recent study. As a direct result, fetal loss (based on *all* pregnancies) decreased from 41.8% to 33.3%. Conversely, survival rate based on *all* pregnancies increased from 58.2% to 66.7%. The proportion of viable pregnancies remained about the same.

Table 3 lists results of *viable* pregnancies defined as total pregnancies minus abortions. The survival rate based on *viable* pregnancies increased from 71.6% pre-1958 to 83.9% during the next 10 years. This was due primarily to fewer neonatal deaths in the recent series.

Table 4 lists fetal outcome based on severity of diabetes according to White's criteria. There were insufficient data to classify two patients. As indicated by spontaneous abortions and stillbirths among classes C and D, severity of disease is an important factor determining fetal outcome.

Table 5 summarizes the relationship betweeen diabetic regulation and fetal outcome. Again, as indicated by abortions and stillbirths among poorly controlled or unclassified patients, control of disease is an important determinant of fetal outcome. Patients listed as unclassified were those whose prenatal care was so inconsistent that insufficient blood sugars, urine sugars, or prenatal visits were recorded to be certain of the degree of regulation. Most of the unclassified would fit the criteria for poor regulation; that is, inconsistent care equals poor regulation.

Table 6 takes this consideration into account and restates the data of Table 5.

Discussion. Insulin therapy and teamwork between obstetrician, internist, and pediatrician have improved the outcome of diabetic pregnancy. For instance, maternal mortality has decreased from rates as high as 55% to rates now less than 1%.[4, 5] Fetal loss from *viable* pregnancy in diabetic women was as great as 40% in the 1930s. In the 1950s the rate had been less than 10%.[6, 7, 8] However, *total* fetal wastage (spontaneous and therapeutic abortions, intra-uterine and neonatal deaths) and congenital abnormalities are still problems of diabetic pregnancy.

Although the basic treatment of diabetes during pregnancy is the same as that during the nonpregnant state, additional factors must be considered. Our aim of management includes:

(1) meticulous control of diabetes and prevention of acidosis,
(2) prevention of excessive weight gain,
(3) prevention and early adequate treatment of infection, and
(4) careful selection of the delivery date.

A major factor in the regulation of our patients is close dietary control including frequent counseling by a dietitian. Insulin requirements we adjust to meet individual needs, and most of our patients in White's groups C and D require a mixture of regular and intermediate-acting insulin. To prevent hypoglycemic reactions, we prescribe snacks between meals and before bedtime. At the first onset of acetonuria, with or without mild infection of the upper respiratory tract or urinary tract, the patient's internist–diabetologist is notified. If necessary, the patient enters the hospital.

Some patients were regulated on oral antidiabetic drugs without side effects on mother or child. Sodium intake is restricted following excessive weight gain and/or edema of the legs. Patients are seen monthly during most of their pregnancies and almost weekly during the last six to eight weeks before delivery. Choice of vaginal delivery or caesarean section depends on obstetrical considerations and is determined by members of the department of obstetrics and gynecology. Early in the management of diabetic pregnancy, all members of the team, including the pediatrician who will manage the newborn, communicate closely with each other. This approach has been fostered particularly by Baldwin, one of the authors of the earlier review.[1] The same team concept continued in our series and continues today.

TABLE 3—*Results of VIABLE PREGNANCIES in Diabetic Women. Earlier and later studies at St. Joseph's Hospital.*

Years	Viable Pregnancies*	Stillbirths	Neonatal Deaths	Surviving Infants
1938–1957	74	9 (12.2%)	12 (16.2%)	53 (71.6%)
1958–1967	62	9 (14.5%)	1 (1.6%)	52 (83.9%)

*Total pregnancies minus abortions.
All percentages based on viable pregnancies.

TABLE 4—*Severity of All Diabetic Pregnancies and Fetal Outcome. Study at St. Joseph's Hospital 1958–1967.*

Classes	A	B	C	D	Severity Unknown	Total Pregnancies
Survivors	11	14	13	13	1	52 Live Births
Neonatal Deaths	0	1	0	0		1 Fetal Loss
Abortions	1	4	7	3	1	16 Fetal Loss
Stillbirths	0	1	5	3		9 Fetal Loss
TOTALS	12	20	25	19	2	78

TABLE 5—*Diabetic Control and Fetal Outcome. Data from St. Joseph's Hospital 1958–1967.*

Fetal Outcome	Excellent Regulation	Good Regulation	Poor Regulation	Unclassified	Total Pregnancies
Surviving Infants	19	5	22	6	52 Live Births
Neonatal Deaths	0	0	1	0	1 Fetal Loss
Stillbirths	2	2	5	0	9 Fetal Loss
Abortions	0	0	10	6	16 Fetal Loss
TOTALS	21	7	38	12	78

TABLE 6—*Infant Survival as a Function of Diabetic Control. St. Joseph's Hospital 1958–1967.*

Diabetic Control	Viable Pregnancies	Surviving Infants	Fetal Losses
Excellent	21	19 (90.5%)	2
Good	7	5 (71.4%)	2
Poor and Unclassified	50	28 (56.0%)	21
TOTALS	78	52	25

Percentages based on viable pregnancies in each category of control.

The most striking improvement in the recent series compared with the previous series is the lesser neonatal death rate. All newborn babies are monitored immediately by an attending physician. Some of the complications expected in the newborn of diabetic mothers occurred, but because of careful management, there was only one neonatal death (in 1959).

The area needing the most improvement in future diabetic pregnancies is prevention of abortions and stillbirths, most of which occurred in severe diabetes—White's classes C and D. Equally, most of these occurred in patients whose regulation was poor or unclassified.

Many of the unclassified patients had juvenile diabetes and tended to be unreliable. Sufficient rapport could not be established with them to obtain the frequent office visits and prenatal and diabetic care that are so necessary. Only hospitalization removes them from their poor social environment so that their diabetic regulation can be improved and subsequent abortions and stillbirths minimized.

ACKNOWLEDGMENT: The authors are indebted to James E. Linzmeyer, RN; Raymond E. Burrill, MD; Frederick J. Wenzel, BS; and all the members of the Departments of Internal Medicine, Obstetrics and Gynecology, and Pediatrics of the Marshfield Clinic for their cooperation in this study, and to Mr. Al Zimmermann for his assistance in the preparation of the manuscript.

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NEW RESEARCH ON DRUGS

Nitrogen mustard: Provided definite improvement in 10 of 12 patients suffering from resistant psoriasis. The drug was applied topically in an aqueous solution by Drs. E. Epstein, Jr. and A. R. Ugel, National Institutes of Health, Bethesda, Md. —AMERICAN DRUGGIST, Jan. 11, 1971 □

Sulpiride: Produced excellent results in 13 of 31 patients suffering from typical migraine when given in an oral dose ranging from 100 mg to 200 mg daily. An additional 12 patients showed definite improvement, while partial improvement was noted in 3. Poor results were seen in only 2 patients. By Dr. Y. Barre, Versailles, France.—AMERICAN DRUGGIST, Jan. 11, 1971 □

Keratoacanthoma

By Rudolph J. Scrimenti, MD, Milwaukee, Wisconsin

KERATOACANTHOMA is a paradoxical skin tumor whose clinical spectrum is continuously widening. This report outlines some features of this important lesion.

Review of the literature. Hutchinson[1] first described this tumor in 1888 in a series of papers entitled, "Crateriform Ulcer of the Face." In 1934, Smith[2] recorded cases with multiple lesions, some of which were familial. Eruptive keratoacanthoma, where small lesions cover most of the body, was documented in 1950 by Grzybowski,[3] and in 1968, Winkelmann and Brown[4] reviewed the clinical features of seven recognized cases in the world literature. In recent years, numerous additional reports of clinical variants have appeared paralleling increased awareness of this lesion.

Presented at the 129th Annual Meeting of the State Medical Society of Wisconsin, May 12–14, 1970, Milwaukee.

Doctor Scrimenti is Assistant Clinical Professor, Department of Dermatology, Medical College of Wisconsin, Milwaukee.

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Clinical and pathologic features. The morphologic prototype is a dome-shaped nodule with a central depression or operculum filled with a keratinous plug. The tumor undergoes a rapid growth phase followed by a stationary period. Then, characteristically, spontaneous resolution occurs. A depressed, frequently scalloped scar usually remains. The entire cycle usually takes two to eight months. The classic microscopic features include a keratinous central plug, pseudoepitheliomatous hyperplasia with an overhanging marginal lip, and a lymphohistiocytic infiltrate often exhibiting exocytosis. The pilary apparatus is apparently not essential for formation of the tumor.

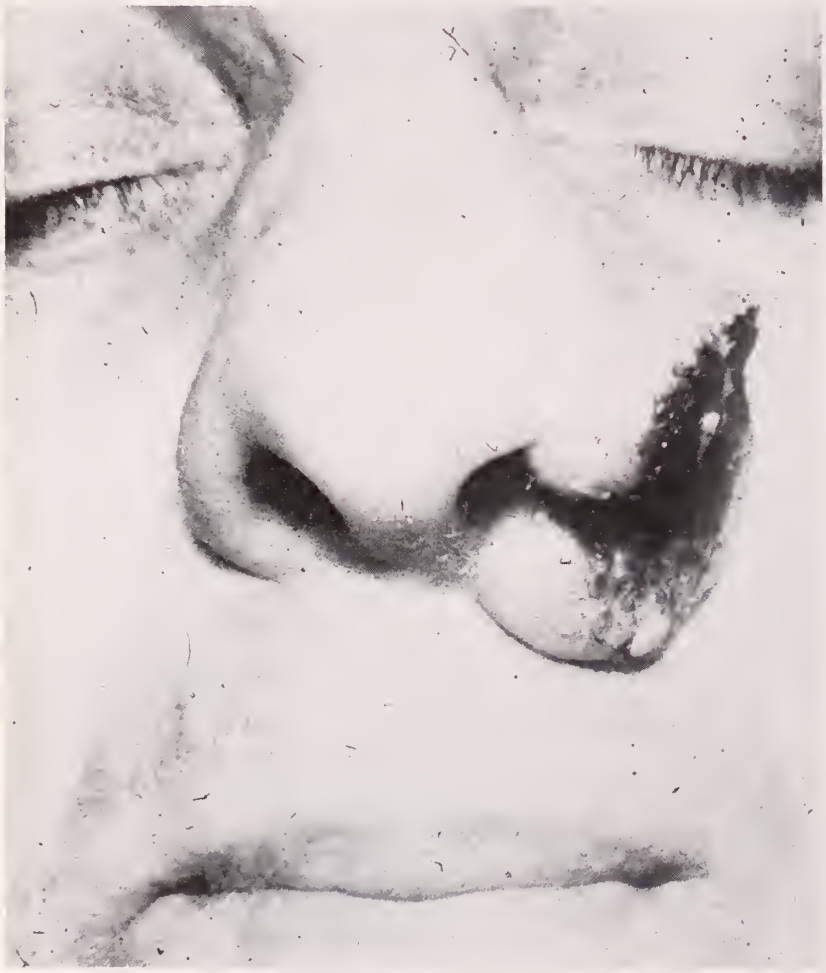

Fig. 1—Keratoacanthoma of the Ala Nasi.

Variants. Many less well-defined variants are being recognized. These include the following: button-like lesions without keratotic plugs, horn-like tumors, post-traumatic lesions, aggregated forms, verrucous growths, vegetating masses, multinodular-coelescent types, mucosal and subungual tumors, ulcero-vegetative lesions, peripherally enlarging types, and giant forms. The face, hands, and forearms are the sites of predilection. However, the entire skin surface and mucous membranes may become involved, especially with the multiple type of keratoacanthoma.

Course. The essential biologic feature of keratoacanthoma is its tendency to disappear spontaneously with crenulated scarring. Nevertheless, some lesions may take many months or even years to regress. Characteristically, giant forms and subungual tumors are destructive, at times mutilating and quite slow to resolve. The prognosis should be guarded when numerous lesions are present. Brown and Fryer[5] have pointed out that while some lesions disappear, others may appear so that "the body may rid itself of these lesions, but it does not seem to be able to dispose of the underlying tendency." Recurrences may occur and are not uncommon in patients with multiple, subungual, and mucosal lesions.

Subungual Keratoacanthoma

Report of Case with Multiple Digital Lesions

By Rudolph J. Scrimenti, MD and George J. Korkos, MD
Milwaukee, Wisconsin

SUBUNGUAL KERATOACANTHOMA is a recently delineated, rare, and distinctive tumor. A recent survey of the literature uncovered eight histologically documented cases, excluding those patients with eruptive keratoacanthoma.[1] In this report we present a patient with multiple digital keratoacanthoma. Two lesions were subungual. One partially destroyed a thumb necessitating amputation after conservative surgical therapy failed. Surgical excision proved adequate therapy for the rest of the tumors.

Doctor Scrimenti is Assistant Clinical Professor, Department of Dermatology, and Doctor Korkos is Assistant Clinical Professor in Plastic and Reconstructive Surgery, Medical College of Wisconsin, Milwaukee.

Reprint requests to: Rudolph J. Scrimenti, MD, 5255 North Hollywood Ave., Milwaukee, Wis. 53217.

Case Report. A 42-year-old caucasian male consulted one of the authors in 1966 because of a painful swelling of the distal portion of the right thumb, resembling paronychia. The lesion had resisted therapy for two years.

Examination revealed an inflamed, indurated, subungual tumor, which had destroyed part of the nailplate (Fig 1). Keratotic, caseous material extruded from beneath the posterior nailfold. Regional lymph nodes were not palpable. The skin was otherwise

Fig. 2—Spontaneous resolution showing crenulated scarring.

Therapy. Incisional biopsies are usually inadequate for diagnostic purposes unless they include the entire central portion of the tumor down to the subcutis. Although this seemingly benign, self-healing tumor may be managed by masterful inactivity, conservative surgical removal is advised in most instances. Treatment should be individualized in all cases. Eruptive, recurrent, multiple, giant, and subungual keratoacanthomas may present therapeutic dilemmas.

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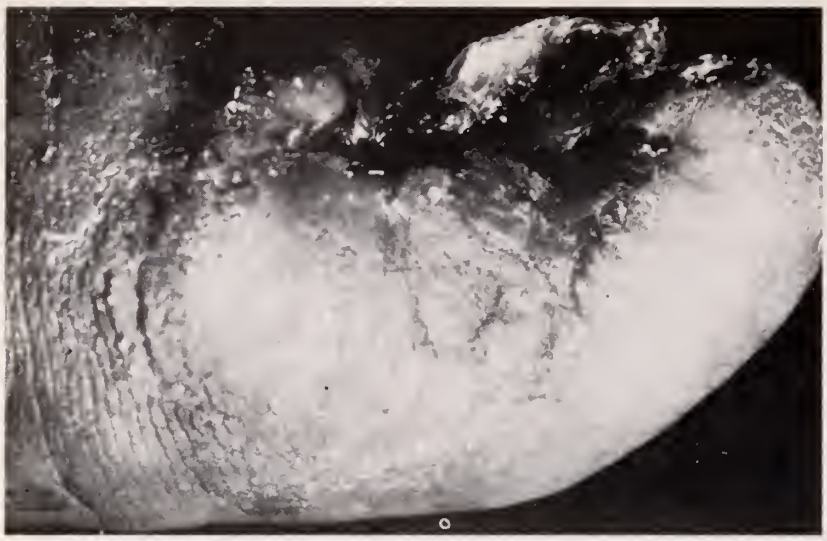


Fig. 1—Subungual keratoacanthoma of right thumb destroying the nail plate.

Fig. 2—Destruction of distal phalanx without periosteal reaction.

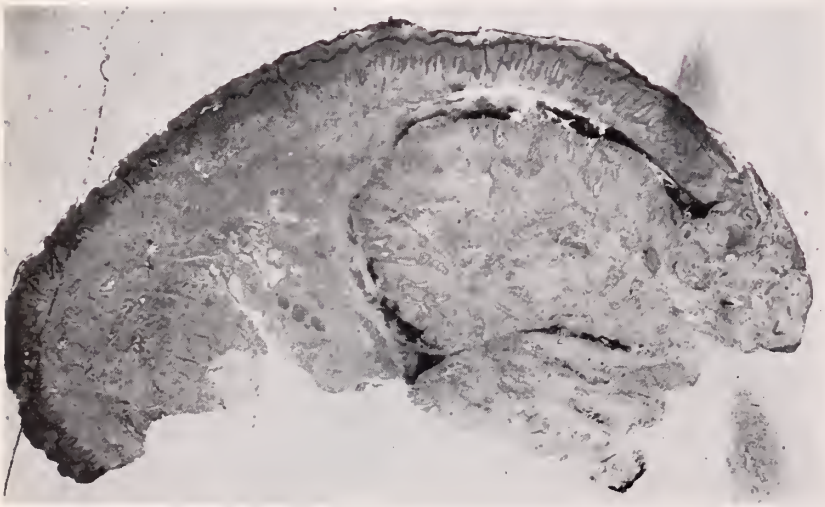


Fig. 4A—Low magnification of amputated specimen. Large keratin crater invaginating the epidermis which extends over sides of crater. Irregular, hyperplastic epidermis extending into corium.

Fig. 3—Recurrence of keratoacanthoma extruding keratinous material.

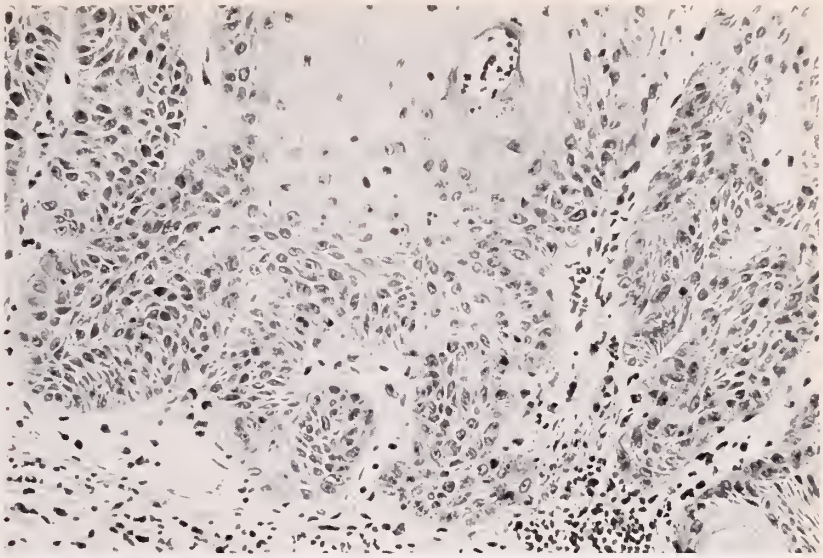
normal. Roentgenogram demonstrated a smooth defect of the distal phalanx. No periosteal reaction was noted (Fig 2).

After removing the nail, the tumor was excised and the base extensively curetted. The histopathologic diagnosis was keratoacanthoma.

Several weeks later, the patient developed a total of six discrete, keratotic papules on the thumb, index, and long fingers of the other hand. The lesion of the index finger was subungual. These were excised and the wounds closed primarily. The subungual lesion required skin grafting for skin closure. Microscopically, these lesions showed identical changes of keratoacanthoma. The surgical sites healed well.

However, five months later, the subungual lesion of the right thumb recurred (Fig 3). It was excised again. Paradoxically the histological features were benign, but very aggressive. A diagnosis of malignancy was strongly considered. Three weeks later the patient returned with an excruciatingly painful and incapacitating second recurrence. The right thumb was then amputated at a level proximal to the distal joint. Serial sections of the amputated specimen showed keratoacanthoma with adherence to the periosteum. Neoplastic invasion of bone was not seen (Fig 4).

Fig. 4B—Higher magnification of epidermal proliferations showing relatively uniform prickle cells and inflammatory infiltrate.



Review of the literature. Fisher is credited with first reporting subungual keratoacanthoma in 1961.[2,3,4] In his remarkable case, the patient had developed multiple subungual and periungual tumors of many fingers for over 20 years. At least two tumors healed spontaneously requiring up to four years to run their course. Lampe *et al* documented three cases in 1964, none of which had multiple lesions.[5] In 1970 Shapiro and Barraf surveyed the literature adding four case studies of their own.[1] One patient had two lesions. Two others experienced recurrences after surgery. Amputations are recorded in at least three cases of subungual keratoacanthoma in the literature.

Discussion. The essential biologic feature of keratoacanthoma is spontaneous resolution. This usually occurs within several months. However, excluding Fisher's case, this has not occurred in any other reported cases of subungual keratoacanthoma. The course of this tumor appears to be quite prolonged. Also, the tendency to spontaneous regression is definitely decreased in patients with multiple keratoacanthoma. Undoubtedly, these patients may be treated before sufficient time elapses for the tumor to run its natural course. The self-healing feature of Fisher's case appears to be the link between these lesions and keratoacanthoma in general.

In the authors' case of multiple keratoacanthoma of the digits, one subungual lesion recurred twice. The literature supports the fact that recurrence is not uncommon.

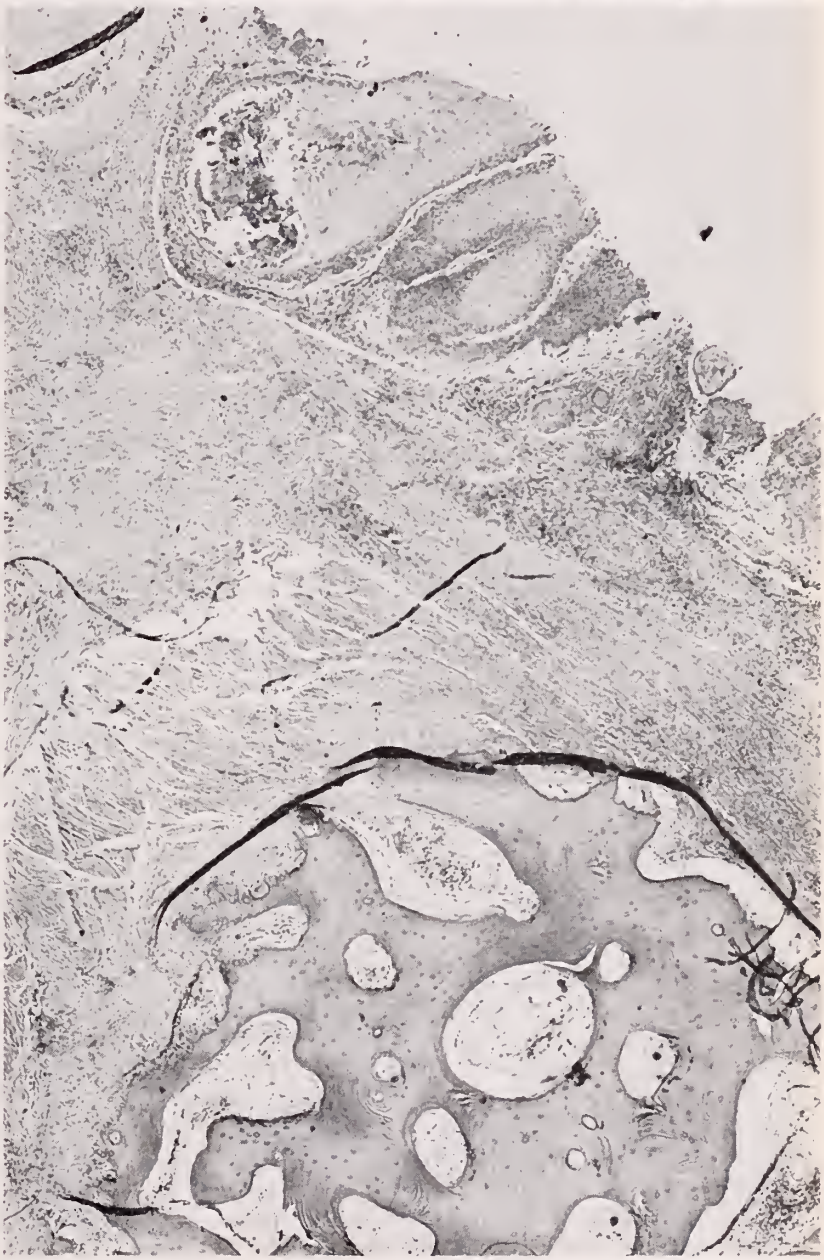


Fig. 4C—Keratoacanthoma extending to bone. Note absence of neoplastic invasion.

Roentgenographic evidence of bone destruction has been present in all reported cases, at times being demonstrable within a month of the onset of the tumor.[1] Presumably, this is due to pressure erosion rather than neoplastic invasion. This supposition is supported by the smooth radiolucent outline of the bony defect and the pathologic features of our case.

The authors agree with the suggestion that conservative surgical therapy of this tumor is the treatment of choice. In most instances, the results of such therapy have been rewarding. Nevertheless, in those cases causing bone destruction, intractable pain, and marked disfigurement, in which conservative management has repeatedly failed, a more radical surgical procedure may be indicated. In the authors' case, the question of malignancy was the most important determinant in their choice of therapy.

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Haemophilus influenzae in Cultures of Cerebrospinal Fluid

B. W. CATLIN, PhD, Department of Microbiology, Marquette School of Medicine, Milwaukee, Wis: *Amer J Dis Child* 120:203–210 (Sept) 1970

Cerebrospinal fluid from a child with meningitis was found by immunofluorescence microscopy and by culture to contain a heterogeneous population of *Haemophilus influenzae*. Most of the bacteria possessed type B capsules and formed irideseent colonies. However, a few lacked typical capsules, and produced nonirideseent rough colonies; though nontypable by the capsular swelling reaction, these bacteria synthesized type B antigen which appeared as discrete embossments.

Embossed variants arose spontaneously in 23 of 25 other freshly isolated strains of *H. influenzae* type B also. Genetic tests of various embossed bacteria and of preparations of deoxyribonucleic acids extracted from them showed that this variation involves a heritable change. The frequency with which this variation occurred suggests that some 'nontypable' *H. influenzae* found by other investigators in pediatric specimens may prove to be typable by immunofluorescence. □

Meningioma: Helpful Technique for Easier Removal

BAHIJ S. SALIBI, MD and CESAR N. REYES, MD, Marshfield Clinic, Marshfield, Wis: *Arch Surg* 101:539–540 (Oct) 1970

A standard technique for removal of A–V malformations is adaptable to some meningiomas. This consists of first clipping and dividing the feeding arteries, thereby allowing the tumor to collapse or shrink by drainage of the blood contained in its vascular channels. Cleavage planes are then easily developed, and the tumor removed in toto, with ligation and division of its draining veins at the very end. This obviates the need for the usual piecemeal removal and its attendant blood loss.

Three moderately sized meningiomas were removed by this technique. Each one was delivered in toto, with relatively little blood loss, and with visible shrinkage of each tumor after clipping and division of the feeding arteries. All three were in poor risk patients: one because of age 72 plus arterial hypertension, one because of a bleeding tendency, and one because of age 71 plus diabetes mellitus. All three patients are doing well, and are back to their normal activities.

This technique may require stereoscopic angiography before surgery. It is not applicable to all meningiomas, but only to those in which the feeding arteries can be localized on the preoperative angiograms. When applicable, it may be particularly helpful in poor risk patients whose tolerance for blood loss is limited. □

Juvenile Ulcers

MARGARET PROUTY, MD, Department of Pediatrics, Jackson Clinic, Madison, Wis: *AFP/GP* 2:66–71 (Sept) 1970

A 17-year study of 331 juvenile ulcers has led to a number of well-defined impressions. Duodenal ulcer should be suspected in any child with "stomachache" in the periumbilical area, especially if it occurs during the school year.

Incidence is highest in the 7-to-9 age group, and 44% have an accompanying frontal headache believed to be on the basis of tension. Having many emotional problems, the child with ulcer tends to be an insecure, nervous perfectionist, who does not enjoy school despite good marks and who has unusually strong needs of affection and praise. Sixty-five percent of the children in the study had relatives with ulcer. □

EDITOR'S NOTE: This article is a follow-up to two previously published articles in the *Wisconsin Medical Journal*—August 1962 and June 1966.

Hematology Control Service

of the Wisconsin Society of Pathologists

By Theodore Rowan, MD, Beaver Dam, Wisconsin

THE WISCONSIN SOCIETY OF PATHOLOGISTS began a Chemistry Control Program in the State of Wisconsin in 1962 in an attempt to improve the precision and reliability of chemistry determinations performed within laboratories throughout the state. This was one of the first programs of its kind initiated at the state level. It has continued since that time and been very well received. Although other programs had been in existence, it was only during this decade that great expansion occurred in quality control programs. Additional programs have been developed and expanded since, particularly those of the College of American Pathologists and the American Society of Clinical Pathologists.

In 1964 the Wisconsin Society of Pathologists expanded its program through a Committee on Continuing Education with the development of a Hematology Control Service. This, the first known state pathology society's program of its kind, was organized primarily for the benefit of the bench technologists and technicians to supplement quality control in hospital (or clinic). Monthly mailings of a blood slide and a fluid sample of blood or urine were made and infrequently other specimens were mailed (2 immunohematology and 2 fecal specimens in 5 years). The charge for this service was $18.00 a year. Thus a means was established by which one laboratory could compare results, techniques, and perhaps personnel with other laboratories.

Mechanism of operation. On the first Monday of each month two samples were sent to each participant. The samples were either one blood slide and one fluid blood sample, or two slides, or one slide and one urine specimen. The blood slides were initially sent out stained, but because of lack of uniformity of staining they were replaced by unstained slides, the staining being performed by the subscribing laboratory. The tests were supposed to be performed as soon as possible and the results mailed back within three days.

On the last Monday of each month a compilation was made of the results of all participants and the reports were mailed to each individual. Each report contained the opinions of three hematology consultants of national repute on the abnormality present in the blood smears with a breakdown of cells noted, as well as a synopsis of the participants' reported comments on the blood smears.

A detailed relevant history and findings of the patient from whom the blood smears were obtained were given with a final diagnosis. In addition a scattergram was made on all fluid blood determinations (hemoglobin, hematocrit, red blood cell and white blood cell determinations), and many urinalyses that were quantitatively estimated had a standard deviation derived.

The survey materials were provided principally by the director of the Hematology Control Service, but many pathologists kindly contributed sets of slides and histories which were used. (See below.)

Participants. The consultants who gave freely of their time and skills were John B. Miale, MD, University of Miami (1964–1969); Dorothy Sundberg, MD, University of Minnesota (1964–1969); Steven O. Schwartz, MD, Hektoen Institute for Medical Research, Cook County Hospital (1964–1967); and Frank Oski, MD, Hospital University of Pennsylvania, Philadelphia (1967–1969).

Forty-two hospitals originally contributed to the service and between 40 and 50 continued to support the program throughout its five years.

Materials Utilized. The service began in August 1964, and was discontinued in July 1969. Each year in August a summary report was sent to each participant, reviewing the materials sent and the associated diagnosis. During the five years of the program, the following materials were mailed:

Blood slides demonstrating the following diseases, conditions, or findings: thrombocytopenia; megaloblastic anemia, pernicious anemia type (4); lymphosarcoma cell leukemia; 60% band form neutrophils; acute myelogenous leukemia; subacute myelogenous leukemia (2); chronic myelogenous leukemia (3); infectious mononucleosis (4); acute leukemia (5); chronic lymphatic leukemia (2); erythroblastosis fetalis; acute hemolytic uremic syndrome; erythroleukemia (2); lymphatic leukemia; viral bronchitis (with lymphocytosis); measles; anemia, myelophthisic type (3); stem cell leukemia (2); Chediak–Higashi disease; congenital spherocytic anemia (3); dysproteinemia of Waldenstrom; leukocytosis with bronchopneumonia; malaria (2); multiple myeloma (3); systemic lupus erythematosis; sickle cell anemia; auto agglutination (with high cold agglutination titer); macrocytosis associated with liver disease

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(2); lymphocytosis associated with viral lymphadenopathy; lymphocytosis associated with herpes zoster; lymphocytosis associated with viral pneumonia; lymphocytosis associated with viral pericarditis; basophilic stippling associated with lead poisoning (2); ovalocytosis; Naegeli type myelomonocytic leukemia (2); Schilling type monocytic leukemia; granulocytic leukemic reticuloendotheliosis; toxic pancytopenia with pseudo Pelger–Huet anomaly; spherocytes with hemolytic anemia (2); reticulum cell sarcoma of bone (marrow); glucose 6 phosphate dehydrogenase deficiency (smear normal).

Urine samples were sent for the following determinations: bile and urobilinogen (strongly positive); salicylates; sugar; blood and amylase; lactose; alcohol; albumin and sugar; PSP; creatinine (2); alkaptone bodies and melanin; Bence Jones protein; acetone and barbital; pH and sugar; formed elements (Addis count); calcium and blood; urea and urea clearance; lactose and pregnancy test; D-xylose, blood and acetic acid; protein, blood, salicylates and urates; sulfa crystals; melanin; casts; alkaptone bodies; sodium, potassium and chloride; calcium; protein, blood, sugar and casts; porphyrins; 5 hydroxy indole acetic acid; pregnancy test and bile; alcohol and creatinine.

Fluid blood samples or commercial standards were sent for the following determinations: hemoglobin (12); red cell count and hematocrit (5); white cell count (2).

In addition the following miscellaneous specimens were sent out: serum containing anti-c (hr'); fecal specimens for ova and parasites (2) [one with Ascaris, the other Dibothriocephalus latus]; and serum for a pregnancy test.

Comment. The majority of participants were active, interested, and helpful, although every month there were a variable number of absent returns. Results generally were good, the principal abnormalities on the slides being noted by the majority and occasionally by all. Scattergram results of hemoglobin determinations, for example, usually showed a standard deviation of less than 0.3 gm/100 ml which is excellent for a mixed group and would be satisfactory in any hospital laboratory. Such data, however, would be tedious to read in detail and is not included. A general improvement in all parameters was noted over the years. In this respect it is of interest to note that toward the end of 1967 all participants were questioned as to their use of red-cell and white-cell control materials. Of the 24 who replied 14 used red-cell and/or white-cell control materials from once a week to daily, the two others had tried them but given them up as unsatisfactory. This is really a high proportion (two-thirds had used them) in view of the fact that a minority of these laboratories were using an electronic counter and that commercial control materials were in their infancy at that time for cell counting (and still are), and were not entirely satisfactory. The proportion now would undoubtedly be much higher.

It was felt that considerable benefits accrued from this program, despite its deficiencies, with the program being aimed at the practicing technologist and technician, stressing what could be learned by common observation or simple testing.

During 1968 the State Laboratory of Hygiene developed an effective hematology control service, pursuant to its charge of evaluating and accrediting laboratories for the Medicare intermediaries. They developed a comprehensive and larger program by virtue of their tax-supported status as well as available time and personnel. Because of this and the fact that there appeared to be little advantage in dual coverage of this area, especially as there are large numbers of different control programs to which most subscribe, the Hematology Control Service of the Wisconsin Society of Pathologists was terminated in August 1969.

The Committee on Continuing Education of the Wisconsin Society of Pathologists has supported and will continue to support educational and control programs in order to promote the best possible quality control for physicians and hospitals in the service rendered to their patients. Accordingly, despite discontinuation of its Hematology Control Service which has outlived its usefulness, the Wisconsin Society of Pathologists through the Committees on Continuing Education stands ready to offer supplementary or complementary programs to presently existing programs whenever appropriate.

ACKNOWLEDGMENT: The Hematology Control Services wishes to thank the following for their materials and generous contributions to the Service during this five-year period:

Pathologists: MDs J. L. Jaeck, Sheboygan; H. J. Conlon, A. F. Cafaro, E. L. Bemis, R. A. Scheidt (now deceased), and C. P. Erwin, Milwaukee; W. G. Richards, Rodolfo Molina, E. B. Wohlwend, and P. R. Glunz, Beaver Dam; L. W. Kleppe, Beloit; J. M. Lubitz, Oconomowoc; R. W. Steube, Fond du Lac; and A. L. Smith, California (formerly of Milwaukee).

Pharmaceutical Companies: Ortho Pharmaceutical Corp., Raritan, N.J.; Warner–Chilcott Division, Morris Plains, N.J.; Hycel, Inc., Houston, Tex.; and Pfizer Diagnostics, New York.

Hospitals: St. Joseph's and Lutheran Hospitals, Beaver Dam; Waupun Memorial Hospital; St. Luke's Hospital, Milwaukee; Rockford (Ill.) Memorial Hospital; Watertown Memorial Hospital; West Allis Memorial Hospital; St. Nicholas Hospital, Sheboygan; Ripon Municipal Hospital; St. Joseph's Hospital, Hartford; St. Agnes Hospital; Fond du Lac; St. Nicholas Hospital, Sheboygan; Beloit Memorial Hospital; Waukesha Memorial Hospital; Lakeland Hospital, Elkhorn; Deaconess Hospital, Milwaukee; and Divine Savior Hospital, Portage.

In addition to the persons and organizations referred to in the text for their help and cooperation, I would like especially to thank the following:

R. A. Scheidt, MD of Milwaukee (now deceased), the original chairman of the Committee on Continuing Education, for his help and assistance in starting the Hematology Control Service.

Rodolfo Molina, MD, Beaver Dam, who assisted in sending out many of the monthly samples.

Yoshiro Taira, MD, Milwaukee, chairman of the Committee on Continuing Education. □

Hyperparathyroidism

A Review of 45 Cases

By Jon Hillegas, MD and William E. Evans, MD
Milwaukee, Wisconsin

SINCE 1960, FORTY-FIVE PATIENTS with primary hyperparathyroidism have been operated upon on the Surgical Services of the Marquette (now called Medical College of Wisconsin) Integrated Residency Program. This series is comprised of thirty-eight patients with a single adenoma, two patients with hyperplasia, and five patients with multiple adenoma, three of whom required a second surgical procedure. Two patients had familial hyperparathyroidism, and both had multiple adenomas. Carcinoma of the parathyroid was not seen. Patients with secondary hyperparathyroidism or incidental autopsy findings of parathyroid tumors were not included.

Clinical Data. Sixty percent of the patients have been operated on during the past five years, indicating an increasing frequency in the diagnosis of hyperparathyroidism, as noted by others.[1,2] The age of the patients at the time of surgery is shown in Figure 1. The average age was 49 years, and two-thirds were less than 60 years old. The youngest was 19 years old. The age range correlates with Cope's observation that hyperparathyroidism, like other endocrine diseases, is rare before puberty or in later life.[3] Twenty-nine patients (64%) were male. If the selective group of Veterans Administration Hospital patients—of which there were sixteen males and one female—are excluded, the ratio of males to females is about 1:1.

Urinary tract symptoms were the most common reason for the patients to seek medical attention. Twenty-one patients (47%) had symptoms related to the urinary tract as their chief complaint. Seven patients had gastrointestinal symptoms while seven patients were seen for constitutional symptoms such as weakness, malaise, and headache. Three patients had skeletal complaints, while one patient had pulmonary symptoms related to previously diagnosed sarcoidosis, one patient had cardiovascular symptomatology, and one patient was evaluated after an exacerbation of gout. Three patients returned because of recurrence of hyperparathyroidism. Four patients were asymptomatic. Three of these were noted to have hypercalcemia on blood screening tests (SMA–12 panel) during routine physical examination for employment, and one patient was evaluated after his mother and brother were noted to have hyperparathyroidism.

A more comprehensive breakdown of the individual patient's status was obtained after detailed review of the patient's hospital chart, which included physical findings, laboratory and roentgenographic results, as well as additional historical data. This technique had previously been utilized by one of the authors in reporting patients with hyperparathyroidism.[4] The data is summarized in Figure 2. When reviewed in this manner, twenty-seven patients (60%) had a previous and/or present history of urinary tract disease. Twenty-two (49%) had a previous history of ureteral calculi; in three the initial episode of ureteral calculi resulted in their hospitalization and subsequent definitive treatment of their hyperparathyroidism. In addition, six other patients had recurring ureteral stones present at definitive admissions. Ten patients (22%) had nephrocalcinosis demonstrated radiographically. One patient had a urinary tract infection present without calculi and four patients complained of marked polydipsia and polyuria. Only three patients had impairment of renal function with blood urea nitrogen levels greater than 20 mg/100 ml and serum creatinine over 1.2 mg/100 ml.

Fourteen patients (31%) had symptoms or findings of gastrointestinal disease. In five there was either previous or present radiographic documentation of duodenal ulcer. Nine patients had previous cholecystectomies for cholelithiasis and two patients had acute cholecystitis on admission. One of these patients also had an associated acute pancreatitis. Twenty-one patients (46%) gave a positive history of constitutional symptoms when questioned in detail. The symptomatology included weakness, fatigue, malaise, lassitude, headaches, and constipation. Five patients had complaints of joint pain or low backache. Of the four patients who were asymptomatic initially, only one gave a positive response to further questioning and her symptomatology was of a constitutional nature.

Familial hyperparathyroidism existed in two brothers in our series. Their mother had had a parathyroid adenoma removed previously at another hospital; the son entered with an initial complaint of low back pain. When the examination revealed hypercalcemia, his sibling, although totally asymptomatic, also was evaluated and noted to have hypercalcemia. In the remaining patients, no family history of endocrine disease or documented urinary tract calculi could be elicited.

Physical examination was not particularly helpful. Hypertension was documented in twelve pa-

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tients (26%), all of whom were 40 years of age or older. Slit lamp evaluation of band keratopathy was not routinely carried out. Neck nodules were palpable in eight patients in this series, and all were of thyroid origin.

Despite the elaborate battery of diagnostic tests which have been proposed, the serum calcium level continued to be the single most important laboratory test in confirming the diagnosis.[5] All patients had documented hypercalcemia preoperatively with the mean range being 12.1 to 13.0 mg/100 ml. Figure 3 summarizes the preoperative calcium determinations. Serum phosphorus was below 3.0 mg/100 ml on at least one determination prior to surgery in all of the forty-five patients. This finding correlates with the authors' previous report.[4]

In thirty-six patients in whom 24-hour urinary calcium determinations were obtained, 86% had values greater than 200 mg/24 hr, and 64% had values greater than 300 mg/24 hr. Twenty of thirty-five patients who had electrolyte studies done preoperatively had chloride levels above 105 mEq/liter (28 of 35 greater than 102 mEq/l). The significance of this previously noted finding of hyperchloremia remains unknown.[4,6]

Special diagnostic tests such as calcium infusion and phosphorus reabsorption were not particularly helpful, and the interest in utilizing them during the past few years has waned. The one exception to this has been the selenium[75]-methionine parathyroid scan which has proved correct for localization of the tumor in seven of nine cases surgically explored.[7]

Radiographic bone changes, primarily generalized demineralization, were noted in fifteen patients. Two patients had osteitis fibrosis cystica. Subperiosteal reabsorption was not reported.

Operative Findings. In all instances the preoperative diagnosis of primary hyperparathyroidism was made and each exploration resulted in the removal of pathologic parathyroid tissue. In thirty-eight instances a solitary adenoma was removed initially. Two patients each had two adenoma removed during their first operation; one of these patients had an intrathyroid as well as a left upper pole adenoma, while biopsies of two other glands were normal, and a fifth gland was grossly normal at exploration. Two patients had hyperplastic glands on microscopic examination.

The two siblings with familial hyperparathyroidism had multiple adenomas. In the case of one, two adenomas (right lower pole and left upper pole) were found at surgery; borderline hypercalcemia persists and he is in the process of re-evaluation. His brother had a single adenoma removed initially and was again explored eight days later when hypercalcemia persisted. Another adenoma was removed and his serum calcium has subsequently been normal. The two other patients requiring a second exploration had adenomas present. One of these second explorations was of the mediastinum and both an adenomatous and a hyperplastic gland were removed. The location of the adenomas (Fig 4) corresponds to that reported in other series.

There were two deaths within 30 days of surgery, both occur-

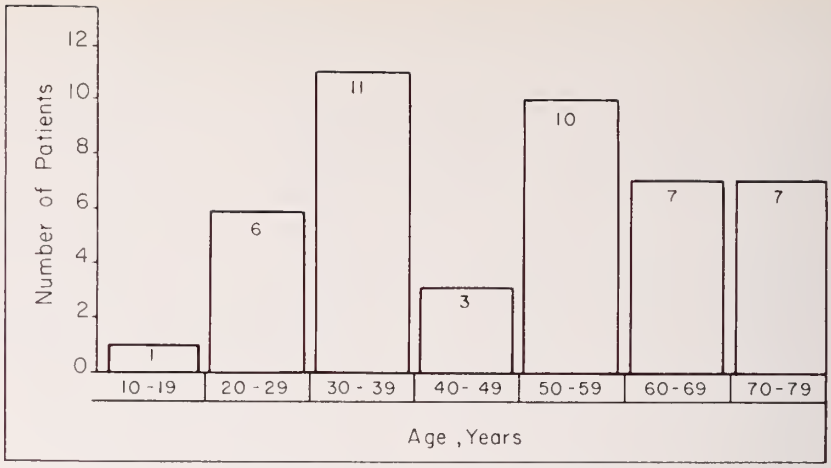

Fig. 1—Age at time of definitive treatment.

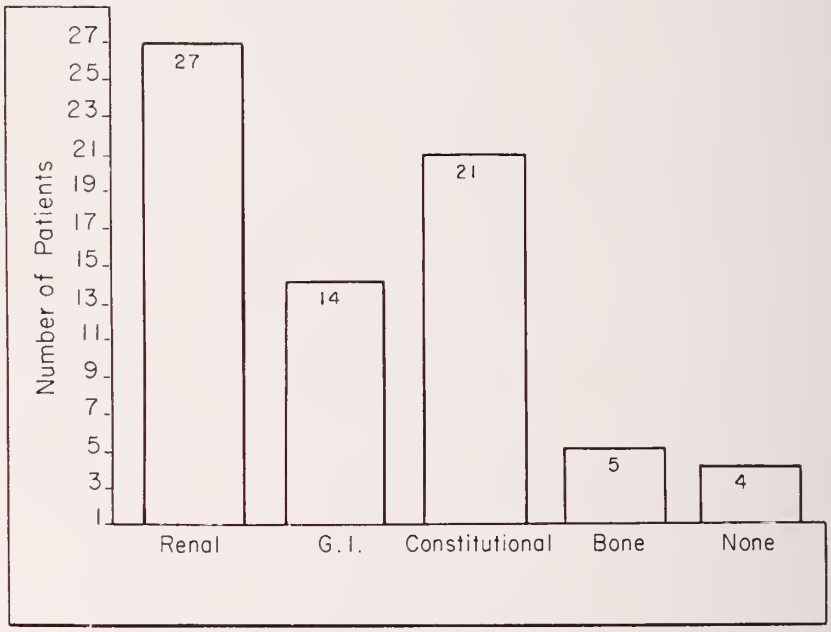

Fig. 2—Summary of signs and symptoms.

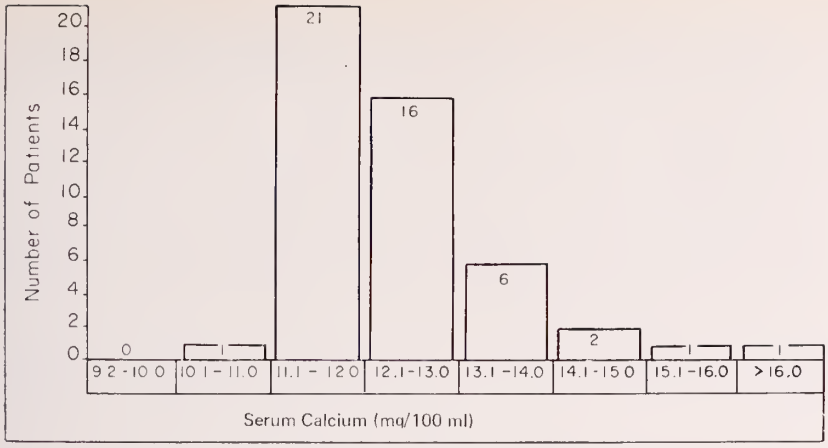

Fig. 3—Preoperative serum calcium mg/100 ml.

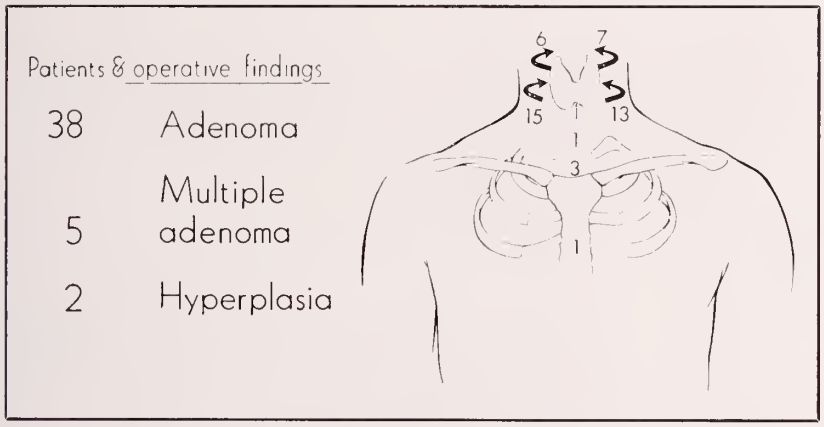

Fig. 4—Location of adenomas (48 patients).

ring in elderly patients (71 and 73 years). One of these patients presented with hyperparathyroid crisis, pancreatitis, and cholecystitis. The patient responded well to emergency excision of a parathyroid adenoma, but succumbed several weeks later to her intra-abdominal pathology.

Comments. The incidence of diagnosis of hyperparathyroidism has risen rapidly over the past five years. This is in a large part attributable to the utilization of the 12-channel autoanalyzer (SMA–12) now in use in most hospitals[8] as well as a greater appreciation of the physiologic alterations of parathyroid function.

For the most part the symptoms complex continues to be dominated by urinary tract findings. Forty-seven percent of our patients presented with renal problems as a chief complaint and overall 60% had a positive review of renal manifestations (primarily calculi) which is in accord with other authors.[1] The incidence of osseous and gastrointestinal manifestations was similar to other reports.

Of significance is the noticeable rise during the past five years in the number of patients with either constitutional symptoms or with symptomatology. All eleven of our patients within these two groups have been seen since 1965 and their cases have undoubtedly been uncovered as a result of increased diagnostic activity. In addition we have noted the pattern of atypical symptomatology which has characterized the elderly patient with primary hyperparathyroidism. As has been recently noted by Thoven and Warner,[9] these patients are more likely to complain of weakness, lethargy, fatigue, and headaches and, until the advent of the screening panels (SMA–12), the significance of these symptoms has been obscure. An increased awareness may lead to surgically remedial disease in these patients.

Serum calcium levels continue to be the most reliable diagnostic measure in these patients. Urinary calcium, serum phosphorus, calcium infusion testing, phosphorus excretion and reabsorption, although helpful are less reliable.[4] No patients have been evaluated by parahormone assay. This procedure will be available in the next several months and will be added to our diagnostic testing in all patients. It is anticipated that this addition will be of great benefit in further clarifying parathyroid function and should be of great help in evaluation of patients with borderline elevations of serum calcium and the previous history of urinary calculi.

Much has been written about the surgical procedure. It is the authors' feeling that the vital issue is the completion of a thorough cervical exploration at the initial operation. With careful exploration based on thorough knowledge of parathyroid anatomy and variation of gland distribution successful results can be obtained in the majority of patients. All four glands should be sought for and exposed prior to excision of any parathyroid tissue. Parathyroid glands normally vary in size, the upper glands being larger than the lower glands, and vary in relation to the pathologic status present.[10] Only with all glands exposed for evaluation can a valid decision safely be made concerning the correct surgical procedure to be carried out.

In those patients harboring a single adenoma, excision of the adenoma is carried out. In addition biopsy of one other parathyroid gland is routinely done. In patients with four parathyroid glands which have been identified, this biopsy procedure can be done without particular danger in terms of future parathyroid function. This additional tissue is of great benefit to the pathologist in evaluating the histology of the pathologic process. In patients

with hyperplasia, the authors' present policy is to remove three glands totally and a portion of the fourth.

Certain surgical dictums have evolved through the authors' experience with this series and the series previously published.

1. Knowledge of the embryology, anatomy, and variations in distributions of the parathyroid glands is mandatory.
2. The operative field must be bloodless.
3. Adequate thyroid mobilization must be achieved; this requires division of the middle thyroid veins.
4. Recurrent laryngeal nerves must be identified and carefully protected.
5. Four glands should be visualized prior to excision of parathyroid tissue.

Summary. Forty-five patients operated upon for hyperparathyroidism on the Surgical Services of the Marquette (now called Medical College of Wisconsin) Affiliated Residency Program have been reviewed. Methods of diagnosis and therapy are outlined.

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Bowel-Gas Explosion During Electrosurgery

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Amer J Surg 120:103–105 (Dec) 1970

Explosion of intestinal gas is a rare but potentially hazardous complication of lower bowel electrosurgery. Prevention depends upon an awareness by the surgeon that combustible bowel gases may be present, the use of cold-knife technique to open the bowel, the avoidance of a preoperative diet containing legumes and milk, and the avoidance of administration of nitrous oxide as an anesthetic agent.

Case report. A 68-year-old woman was hospitalized with severe achalasia. She had undergone esophagoplasty ten years previously, but a stricture gradually developed to the point that she could swallow only thin liquids.

Three weeks before her final admission, she was hospitalized due to dysphagia, vomiting, and weight loss. To prepare her for major surgery, a feeding gastrostomy was performed and she received a daily 2,000-calorie feeding of a food supplement containing milk. Following routine three-day bowel preparation, she underwent interposition of the ascending colon under general intratracheal anesthesia consisting of thiopental (Pentothal®), succinylcholine, nitrous oxide, and halothane.

The ascending colon was fully mobilized. The vascular pedicle was short, and the colon was greatly distended with gas.

As the large bowel was being opened using electrocautery, an explosion occurred. Examination of the bowel revealed multiple tears in the transverse colon which required further resection. Although the colonic graft, which had been isolated and covered, showed petechiae over the distal third, it was considered viable and suitable for implantation.

Because of the explosion and the short pedicle, a median sternotomy was performed to enable use of a longer portion of the patient's proximal esophagus for anastomosis and to reduce tension both on the pedicle and on the cervical esophagocolostomy. The mediastinum and the right pleural spaces were drained and a Levin tube was placed proximally in the graft lumen. The patient's condition remained stable throughout the procedure.

Despite antibiotics, spiking fevers developed on the second postoperative day, purulent material drained from the mediastinum on the eighth day, and the hematocrit level dropped and the drainage material became brown on the tenth day.

Barium swallow examination revealed a defect in the distal graft, and at reexploration on the eleventh postoperative day, a necrotic graft was removed. Despite cervical esophagostomy, feeding gastrostomy, and extensive drainage, the patient became comatose and died on the twelfth postoperative day from presumed gram-negative septicemia.

It was presumed that the explosion resulted from a mixture of hydrogen caused, primarily, by the preoperative milk diet. In addition, excessive amounts of atmospheric gases may have been introduced into the bowel during tube feeding. Administration of nitrous oxide during anesthesia also added to the volume of bowel gas. □

COMMENTS ON TREATMENT

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Management of Glaucoma

By Elieser B. Suson, MD and Richard O. Schultz, MD, MSC
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GLAUCOMA IS A FREQUENT CAUSE of blindness. Available figures indicate that 13.5% of legal blindness in the United States is due to this disease.[1] Since visual loss in most of those afflicted can be averted by early treatment, clinical awareness of the condition is of paramount importance. In spite of its insidious character in the majority of instances, some pertinent information may lead to suspicion of the disease.

Emphasis need be laid on obtaining (1) a family history of glaucoma, (2) recognition of glaucomatous cupping of the optic disc by ophthalmoscopy, and (3) detection of an elevated intraocular pressure by tonometry. However, caution should be exercised in the interpretation of tonometric readings because in some diseased eyes the pressure may be normal during certain times of the day. The abnormal diurnal pressure variation in these eyes can be uncovered by pressure measurements every 3 to 4 hours for 24 hours. It should also be pointed out that in some glaucomatous subjects low ocular rigidity can result in falsely normal readings on the Schiotz tonometer.[2] Applanation tonometry by an ophthalmologist is required to detect this error.

Primary Open Angle Glaucoma. In primary glaucoma there is no demonstrable cause for the rise of intraocular pressure.

Primary open angle glaucoma comprises 60% to 70% of glaucomas[1] in adults and affects about 2% of people over the age of 40 years. There is no sex predilection. The dearth of symptoms and signs early in the course makes it difficult to recognize clinically. A positive family history and the presence of thyrotropic exophthalmos and high myopia should arouse suspicion of the disease. If tonometry is performed a good number can be detected because of elevated intraocular pressure. Also, ophthalmoscopy may reveal glaucomatous excavation (cupping) of the optic disc in well established cases. The final diagnosis rests on the findings of applanation tonometry, tonography, water provocative testing, and visual field examination.

The treatment of primary open angle glaucoma is medical. The miotics and epinephrine topically and the carbonic anhydrase inhibitors orally find their greatest usefulness in the treatment of this disease. Surgery is resorted to only when medical therapy has failed.

Primary Angle Closure Glaucoma. Ten to 20% of all glaucomas is due to primary angle closure.[1] It occurs more often in females, especially in late middle life. During an acute attack, it may be the easiest glaucoma to detect. The patient seeks medical help for pain in the eye, lacrimation, headache, blurred vision, and seeing of colored halos around lights. Examination reveals a markedly injected eye with a cloudy cornea, a very shallow anterior chamber[3] and a non-reactive moderately dilated pupil. Digital palpation comparing the two eyes shows hardness of the involved eye. Tonometry shows moderate to marked rise of pressure. Impaired vision can be demonstrated by proper testing with the Snellen's chart or other methods. Attention should be focused on the fact that sometimes the presence of nausea and vomiting can lead to a mistaken diagnosis of an abdominal condition. In the intermittent type, prior to a sustained acute attack, a history of recurrent headache, blurring of vision and seeing of colored halos around lights may be obtained. Some of these have been misdiagnosed as cases of migraine or neurological disease. In the chronic angle closure type with minimal amount of symptoms, tonometry, examination of the chamber angles by gonioscopy and provocative testing are needed in the diagnosis.

Unlike the open angle type, the treatment of angle closure glaucoma is essentially surgical. When diagnosed early it can be cured by a peripheral iridectomy. In order to avoid complications the intraocular pressure is lowered before surgery using pilocarpine

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topically, acetazolamide (Diamox®) orally or intravenously and glycerol orally. Intravenous mannitol or urea is resorted to only when these measures fail.

Primary Congenital Glaucoma. This condition is rare.[4] However, early detection is important because useful vision can be preserved by timely surgery. About 80% of cases are diagnosed in the first year of life; over 65% are in boys and it is bilateral in 75%. The child presents with tearing, photophobia, squeezing of the eye lids, and large corneas which may be hazy. The optic discs usually show glaucomatous cupping. The finding of a developmental abnormality of the chamber angle[5] by gonioscopy clinches the diagnosis.

Treatment is surgical—the operation of choice being goniotomy. Medical therapy is limited to the preoperative stage.

Secondary Glaucoma. Many diseases secondarily raise intraocular pressure. Some of these are intraocular inflammation, dislocated and hypermature lenses, intraocular tumor, and neovascularization of the iris. Treatment is directed towards the primary condition. It should be stressed that glaucoma secondary to uveitis is best treated with mydriatic drugs such as atropine and phenylephrine and corticosteroids topically, subconjunctivally or systemically, and carbonic anhydrase inhibitors systemically. Miotics are contraindicated in this condition.

Drug Therapy of Glaucoma. Since intraocular pressure is determined by the rate of production and elimination of aqueous humor, the drugs used in the treatment of glaucoma can be conveniently divided into those that decrease aqueous production and those that increase its elimination.[2]

I. Drugs that increase the rate of aqueous elimination—these are miotics. In angle closure glaucoma pupillary constriction induced by these drugs pulls the iris from the angle and relieves the obstruction at this site. In open angle glaucoma the mechanism of the improved drainage of aqueous is obscure.

A. Parasympathomimetics. Like acetylcholine, these act directly on the parasympathetic end-organs in the iris, ciliary body, and trabecular meshwork. Pilocarpine is used as the water soluble hydrochloride or nitrate solution in concentrations of 0.5% to 10%, instilled to the eye from twice daily to as often as every 4 hours. Methacholine chloride (Mecholyl®; acetyl-β-methylcholine) is used in 10% to 20% solutions every 5 to 10 minutes in angle closure glaucoma. Carbamylcholine chloride (Carbachol®; Carcholin®; Doryl®) is used in 0.75% to 3% aqueous solutions every 4 to 8 hours.

B. Anticholinesterases. They inhibit cholinesterase and allow the endogenous acetylcholine to act on the parasympathetic end-organs. Physostigmine salicylate (Eserine®) was the first drug used in the therapy of glaucoma (Laqueur, 1876). The 0.25% to 1.0% aqueous solution is instilled to the eye every 4 to 6 hours. It also may be used as an alkaloid in oily vehicles or as an ointment. Neostigmine bromide (Prostigmin®) is used in concentrations of 3% to 5% every 4 to 5 hours. The following are long-acting anticholinesterases: Isoflurophate (Floropryl®; DFP)—0.01% to 0.1% solution in peanut oil or 0.025% ointment, every 12 to 72 hours. Echothiophate iodide (Phospholine Iodide)—0.03% to 0.25% aqueous solution, every 12 to 48 hours. It should be stored under refrigeration. Demecarium bromide (Humorsol®; BC® 48; Tosmilen)—0.12% to 0.25% aqueous solution every 12 to 48 hours.

Miotics are used primarily in the long-term treatment of open angle glaucoma. Customarily, pilocarpine is used initially. If the therapeutic result is unsatisfactory, the other miotics are tried. In angle closure glaucoma pilocarpine is used preoperatively and, sometimes, following a peripheral iridectomy. In angle closure glaucoma phospholine iodide, demecarium bromide, and isoflurophate are avoided because the resulting vascular congestion and extreme miosis may aggravate the condition.

Miotics may produce ciliary and conjunctival congestion, ocular and periorbital pain, twitching of the lids, headache, blurring of vision from accommodative myopia, and poor vision in dim light from pupillary constriction. In addition, the anticholinesterases may produce nodular excrescences or cysts at the pupillary margin, vitreous hemorrhage, retinal detachment, fibrinous iritis, allergic conjunctivitis, dermatitis, and stenosis of the lacrimal canaliculi. Posterior synechiae and even cataract have been reported following the use of phospholine iodide, demecarium bromide, and isoflurophate. Prolonged use of physostigmine may lead to irritation and follicular hypertrophy of the palpebral conjunctiva.

Systemic side-effects, especially following the anticholinesterases, include nausea, vomiting, diarrhea, bradycardia, salivation, sweating, vivid dreams, depression, and delusions. Depletion of serum pseudocholinesterase by phospholine iodide may lead to prolonged apnea if succinylcholine is used during general anesthesia.

II. Drug that decreases the rate of aqueous secretion as well as increases its elimination. Epinephrine hydrochloride, bitartrate, borate or sulfate is used in concentrations of ½% to 2% every 12 to 24 hours. Its mechanism of action is unknown. Side effects include dryness of the nose, headache, melanin deposits on the conjunctiva and cornea, conjunctival hyperemia, allergic conjunctivitis, macular edema, vascular hypertension, and cardiac irregularities. It is contraindicated in narrow angled eyes prior to peripheral iridectomy. As with other drugs, reactions may be minimized by pressure on the lacrimal puncta soon after instillation to the eye to decrease systemic absorption.

III. Drugs that decrease the rate of aqueous formation. The carbonic anhydrase inhibitors are representatives of this group. Acetazolamide (Diamox®), is given orally in doses of 125 mg every 12 hours to 500 mg every 4 hours. The dosage for infants is 5 to 10 mg/kg body weight every 4 to 6 hours. Diamox® is available also in 500 mg sustained release capsules which can be given orally every 12 hours; and, in ampules containing 500 mg, to be dissolved in 5 to 10 ml of distilled water for intravenous or intramuscular injection. Ethoxzolamide (Cardrase®; Ethamide) is administered orally in doses of 50 to 250 mg every 4 to 8 hours. Dichlorphenamide (Daranide®; Oratrol®), is administered orally in doses of 50 to 250 mg every 6 to 8 hours. Methazolamide (Neptazane®), is given orally in doses of 50 to 100 mg every 8 hours.

The carbonic anhydrase inhibitors (CAI) are used in secondary glaucoma and, commonly, in the long-term treatment of primary open angle glaucoma. In angle closure and congenital glaucoma, generally, its use is limited to the preoperative stage.

The side effects of CAI include transient myopia, paresthesia, loss of appetite, ureteral colic and, recently reported with acetazolamide, gouty arthritis.

IV. Drugs that increase blood osmolality. The hyperosmotic agents increase blood osmolality and lead to loss of water from the eye. Glycerol, the most widely used oral hyperosmotic agent, is administered as a 50% solution in a dose of 1.5 to 3 ml/kg body weight. Its major drawback is nausea and vomiting. In diabetics its caloric value poses a problem especially on repeated administration. Isosorbide (Hydronol), which is presently under investigation, is also administered orally as a 50% solution in doses of 2 to 4 ml/kg. It produces less nausea than glycerol and is excreted unchanged in the urine. Ethyl alcohol, as a 50% solution in fruit juice or as straight whiskey in doses of 2 to 3 ml/kg can be very useful in an emergency situation. It is not employed in long-term therapy. The intravenous hyperosmotic agents, mannitol as a 20% solution, urea as a 30% solution in invert sugar, and sodium ascorbate as a 20% solution, are given in doses of 1 to 2 gm/kg at a rate of 60 drops per minute. The hyperosmotic agents are commonly used in the treatment of acute angle closure glaucoma prior to surgery. Occasionally, they are used for a similar purpose in open angle glaucoma.

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Coping with a Chronic Disability

Psychosocial Observations of Girls with Scoliosis Treated with the Milwaukee Brace

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The adjustment to wearing a Milwaukee brace for scoliosis was studied in 26 girls and their mothers. Sixteen girls were able to adjust well after an initially difficult period, seven had behavioral symptoms which interfered with their adaptation, and two refused to wear the brace. The frequency of problems is probably due to 6 of 25 girls being referred because of management difficulty.

Factors contributing positively to coping included intellectual understanding of scoliosis and bracing, optimistic view of outcome, active decision to wear brace, and support of family and medical staff. Negative factors included poor intellectual understanding, denial of deformity, conflicts between mother and daughter, family problems, and long duration for the brace. There were no significant associations between the girls' adjustment to the Milwaukee brace and indications of distorted body imagery on projective testing. □

Fever During Acute Alcohol Withdrawal

HAROLD D. ROSE, MD et al, VA Center, Wood, Wis: *Amer J Med Sci* 260:112–121 (Aug) 1970

It is well known that fever is a common clinical finding during alcohol withdrawal. We have recently studied 63 patients with acute alcohol syndromes and critically analyzed the cause of fever that appeared among these patients.

Thirty patients experienced a withdrawal syndrome that was limited to the acute tremulous state. There were nine episodes of fever in eight (27%) of them.

The incidence of fever among these patients was no greater than among a control group of nonalcoholic patients admitted during the same period. Thirty-three patients experienced delirium tremens. There were 28 episodes of fever in 27 (82%) of these patients; fourteen of them had fever secondary to pneumonia.

Dehydration was the apparent cause of seven febrile episodes and seven other episodes were of diverse etiology. Fever during alcohol withdrawal usually appears in the hospital at the height of the withdrawal syndrome. Bronchopneumonia and dehydration are the most common and remediable causes of fever. □

Bone Marrow Examination: Reappraisal of Diagnostic Value

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Examination of the bone marrow has become of increasing importance since the first practical techniques of obtaining samples from various osseous sites were introduced. However, it has also become apparent through the years that this procedure has limits and, in many instances, will add little information to that which can be extracted from an adequate history, physical examination, and review of the peripheral blood smear. Therefore, it is important to have clearly in mind those situations where marrow examination can be expected to yield crucial information, and to distinguish circumstances in which the added data may be of diagnostic help from those in which it will not.

The presence of pancytopenia (anemia with leukopenia and thrombocytopenia) constitutes a nearly absolute indication for bone marrow examination. Pancytopenia may have many causes. If it is the result of leukemia, examination of marrow will permit an unequivocal diagnosis to be made. The value of marrow examinations in cases of leukemia is at least two-fold. First, they provide a very important diagnostic tool, especially in cases of suspected acute leukemia that are occasionally subleukemic or aleukemic. Secondly, they are useful in following the course of individual cases of leukemia and in revealing response to treatment. Marrow examination is also helpful in ruling out the diagnosis of leukemia in patients with pancytopenia from some other cause such as miliary tuberculosis or "aplastic anemia." (It should be remembered that the diagnosis of "aplastic anemia" is largely one of exclusion and that marrow obtained from such patients may be either hypocellular, normocellular, or hypercellular. Estimation of bone marrow *function* by the use of ferrokinetic or other studies will more definitively establish the presence of bone marrow failure.)

There are also certain conditions in which characteristic evidence is frequently found in the bone marrow but rarely or never discovered in the blood. Cells of such critical diagnostic importance are likely to be found in aspirations obtained from patients with multiple (plasma cell) myeloma or a lipid-storage disease. A bone marrow needle biopsy specimen will also usually confirm the presence of myelofibrosis or myelosclerosis.

Metastatic tumor cells have been demonstrated by marrow aspiration, especially if fixed tissue sections of the aspirated material have been made, when the diagnosis would otherwise have been obscure or uncertain. The study of sections from aspirated material has also, in certain cases, made possible the demonstration of lesions of brucellosis, miliary tuberculosis, histoplasmosis, Hodgkin's disease, and sarcoidosis in the marrow.

Although examination of the peripheral blood along with other laboratory procedures may establish an unequivocal diagnosis of a megaloblastic process, this is not true for many megaloblastic anemias which occur in infancy and during pregnancy. In these conditions, the alterations in the peripheral blood may not be as striking as they are in typical cases of pernicious anemia and marrow examination remains very useful. Although a thorough search may show the presence of macrocytes, the anemia may be normocytic on the basis of mean corpuscular values even when the marrow is megaloblastic.

There are rare instances, too, of aregenerative anemia, persistent leukopenia, or thrombocytopenia in which bone marrow examination may lead to the correct diagnosis or help to exclude a primary disease of hematopoietic tissue. In obscure fevers and suspected infections in which blood cultures have been negative, culture of a marrow aspirate may show growth of the infectious agent.

Examination of the bone marrow may not yield *definitive* diagnostic information in patients with posthemorrhagic anemia, hemolytic anemia, nonthrombocytopenic hemorrhagic disorders, anemia or nephritis, anemia of infection, polycythemia or infectious mononucleosis. However if the clinical picture is not clear, evaluation of erythroid mass, sideroblasts, and storage iron in the marrow combined with reticulocyte production index in the peripheral blood does help to define the mechanism of an anemia. In many instances of chronic myelocytic leukemia and chronic lymphocytic leukemia, a diagnosis can be made without bone marrow examination.

Perhaps the greatest abuse of bone marrow examination has been in patients with the most common form of anemia, that of microcytic hypochromic type. Most instances of this anemia in the adult are due to iron deficiency caused by chronic blood loss, and the presence of such an anemia should immediately direct the attention of the physician toward finding the source of bleeding.

The concomitant state of iron deficiency may be documented by testing for the expected low serum iron and expanded total iron-binding capacity in the blood without resorting to bone marrow estimation of iron stores. Uncommonly, the expected values may not be found and, instead of pointing toward an iron-deficiency state, will reveal instances of pyridoxine-responsive or sideroachrestic anemia (with high serum iron levels). Then, marrow examination with evaluation of iron stores and of sideroblasts will be valuable. □

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Acute Thrombophlebitis

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ACUTE THROMBOPHLEBITIS, with its immediate and long-term sequelae, continues to be the most common vascular problem faced by all physicians. The range of complications includes acute and chronic edema, pain, pulmonary embolus, stasis ulceration, and occasionally, venous gangrene.

Although thrombophlebitis of the upper extremity is not rare and by no means innocuous, the lower extremities are most commonly involved. The disease may be superficial, involving the saphenous veins and their tributaries, or deep with localization in one or more of the following areas: (a) intramuscular venous channels of the calf, (b) the popliteal space, (c) the deep femoral system, (d) the inguinal area, (e) the deep pelvic veins, and (f) the iliac veins.

Intravascular thrombosis results from an imbalance between the natural clotting mechanisms and the natural circulating anticoagulants and fibrinolytic properties of the bloodstream. Virchow[1] first described the probable causes in 1856, implicating changes in the vessel wall such as trauma and intimal damage, stasis, and biochemical changes within the blood (which has been referred to as the "hypercoagulable state"). Certain conditions and diseases lend themselves to an increased incidence of thrombophlebitis by providing one or more of the elements of Virchow's triad. Sise[2] lists several predisposing conditions such as cancer, myocardial infarction, atherosclerosis, congestive heart failure, pregnancy, the postpartum state, the postoperative state, prolonged inactivity or bed rest, fractures, crush injury, and other trauma (Fig 1). Stasis, as described by Mustard[3] retards the removal of clotting factors and provides a decreased supply of inhibitors. The reverse is true in a fast flowing system. Sludging adds to mechanical stasis and is seen particularly in patients with dehydration, burns, after vigorous therapy for congestive heart failure, and in primary or secondary polycythemia.

Hypercoagulability as a physiological state is supported at least by indirect evidence.[2] Increased platelet cohesiveness and adhesiveness can be demonstrated on the fourth to tenth postoperative days, as well as in the postpartum state and in atherosclerosis. These properties are associated with an increased number of platelets and can be reversed with heparin. Many other clotting factors are implicated in the literature[2,3] and further evidence will soon be published by Hussey.[4]

The diagnosis of superficial thrombophlebitis can easily be made by the physical findings of tenderness, erythema, and palpable thrombosed veins, particularly along the course of the saphenous systems and in areas of known varicosities. In the case of deep thrombophlebitis, the diagnosis is frequently difficult to establish. Calf or thigh tenderness, increased warmth, edema, and distal venous engorgement are the hallmarks. The classical Homans' sign has been largely replaced on our service by the Lowenberg calf compression test and direct leg measurements. However, every clinician can bear witness to the patient who has had a fatal or near fatal pulmonary embolus without historical or physical evidence of deep thrombophlebitis. Evaluation of the deep system is based on indirect findings as listed above and often these do not reveal the true picture. Here the phlebogram is of increasing importance.

Since Bauer's classical paper on venography in 1940,[5] the subject has been pursued and modified by many investigators and has had varied acceptance. We

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Fig. 1—Bilateral basilar pulmonary emboli following ankle fracture which required screw fixation of medial malleolus.

Fig. 2—Phlebogram outlining thrombus partially filling the upper popliteal, superficial, and deep femoral veins. Note the classic finding of a halo of dye surrounding a partially occluding clot within the venous lumen.

have made increasing use of this diagnostic method for both superficial and deep disease for several reasons (Fig 2):

1. Some patients have been treated for deep thrombophlebitis because of pain and edema who, by venography, have a normally patent and competent deep venous system (Fig 3).
2. The patient with superficial thrombophlebitis may have associated deep disease which would otherwise go undetected.
3. In the superficial system, the length of the propagating thrombosis may greatly exceed the local findings which are secondary to attachment of the clot. A free-floating clot may extend beyond the saphenofemoral junction into the femoral veins and require saphenous ligation with clot extraction from the femoral vein instead of anticoagulant therapy alone.
4. The patient with pre-existing deep disease may develop superficial thrombophlebitis in an isolated segment of the saphenous system. The patent, remaining portion of the saphenous vein may contribute to the primary venous drainage of the extremity. Inadvertent ligation or stripping of the entire saphenous system may seriously compromise outflow of the extremity (Fig 4).
5. A clinically evident thrombosis within the deep system may propagate cephalad into the femoral–iliac area. Its size and mode of attachment may justify immediate inferior vena caval clipping and/or thrombectomy in spite of the absence of other findings to suggest iliofemoral thrombosis.
6. Venograms are of value in evaluating the degree of involvement as a guide to the rate of recanalization and, therefore, help to determine the duration of anticoagulation therapy.

The technique we use has been simple. Before the patient is taken to x-ray, he is given 100 mg of heparin intravenously to prevent the development or extension of thrombophlebitis from the procedure itself. The patient is placed on the x-ray table with the table tilted 25°, feet down. Fifty milliliters of meglumine diatrizoate (Renografin® 60) are injected through a pediatric scalp vein needle into a vein on the dorsum of each foot, with a tight tourniquet above the malleoli to occlude the superficial vessels

Fig. 3—Bilateral normal phlebogram in a patient with erroneous diagnosis of recurrent thrombophlebitis for seven years.

Fig. 4—Phlebogram in a patient with complete occlusion of the popliteal, femoral, and iliac veins. The greater saphenous vein is the only significant venous drainage channel available.

and force the dye into the deep system. Serial films are taken of the lower legs, popliteal space, thighs, pelvis, and abdomen. The patient performs the Valsalva maneuver as each film is taken, to completely fill collateral systems and demonstrate valves. On the final film, the legs are rapidly elevated to flood the iliac veins and inferior vena cava. All films are reviewed and therapy correlated with the findings. If the films are not adequate, the injection may be repeated and timing of the sequence of the films adjusted. There have been no untoward reactions and there is a minimum of discomfort to the patient, in more than 300 phlebograms performed by this technique.

Conventional therapy for deep thrombophlebitis limited to the calf and popliteal areas includes anticoagulation with heparin for 14 days, elevation of the legs, elastic support, ambulation after the seventh day, and long-term warfarin (Coumadin®) therapy beginning on the eighth day. Warfarin therapy is maintained for at least three months, both to prevent recurrence and to promote recanalization. We have utilized the same regimen for super-

Fig. 5a—Right iliac femoral, popliteal, and calf thrombophlebitis (phlegmasia alba dolens) in a patient two weeks post myocardial revascularization.

Fig. 5b—Bilateral phlebograms ten days post right ilio femoral venous thrombectomy and application of clip to inferior vena cava. Marked improvement in deep venous circulation is observed.

ficial thrombophlebitis for several reasons:

1. Pulmonary embolism, though infrequent with superficial involvement, can be avoided.
2. Progression with deep venous involvement may be prevented.
3. Saphenous ligation may be avoided unless a clot is demonstrated in the upper one-third of the saphenous vein or within the saphenofemoral junction, and saphenous vein stripping can be deferred until the disease is resolved.
4. Associated deep disease which may not be obvious without venograms is controlled at the same time.

In those cases where clot is demonstrated at the saphenofemoral junction, simple ligation of the saphenous vein, with extraction of the clot extending into the deep system, is performed under local anesthesia.

Iliofemoral thrombosis is far more severe in its manifestations and complications. The thrombus, on occasion, may effectively obstruct the main channel and collaterals to such an extent that phlegmasia cerulea dolens develops. Although this occurs rarely, it is a dreaded complication with high mortality and morbidity. Immediate thrombectomy utilizing the methods of Fogarty,[6] Mahorner,[7] and Haller[8] is indicated in phlegmasia cerulea dolens, to prevent venous gangrene of the involved extremity. This can be carried out safely under local anesthesia, in these

Fig. 6a—Phlebogram demonstrating patent inferior vena cava following application of serrated Teflon clip (at arrow). Note the absence of para caval collaterals, indicating normal venous flow without significant obstruction.

Fig. 6b—Phlebogram following inferior vena cava ligation for recurrent pulmonary emboli. Marked development of para caval collateral veins, large enough to permit further pulmonary embolization.

extremely ill patients. There is a small incidence of pulmonary embolization, which can be avoided with an inferior caval occluding catheter from the contralateral femoral vein or by obtaining the patient's cooperation in performing the Valsalva maneuver as a femoral vein is opened and proximal clot extracted. Free flow from both directions must be obtained. Care must be taken to control all tributaries of the common femoral vein with tapes, especially the profunda which is often overlooked, in order to prevent excessive blood loss. Careful hemostasis in the wound must be obtained, since the patient is routinely heparinized in the immediate postoperative period. The immediate results are often gratifying, but the maintenance of a patent deep system with intact valves has not lived up to expectations on followup several years later, according to Lansing.[9] These patients are, of course, prone to the chronic problems of the postphlebitic limb.

In phlegmasia alba dolens, or simple iliofemoral thrombosis with some intact cross pelvic circulation, thrombectomy has been proposed to prevent the long-term sequelae. Here also, late venograms have been disappointing. Some authors even feel that the use of balloon catheters may cause damage to valves, leading to their later incompetence. We are not so pessimistic and we have been especially impressed by the immediate reduction of pain and edema (Figs 5a and 5b).

The studies of Edwards[10] clearly demonstrated that organization of the clot leads to damage of the valves which is irreversible. Therefore, we have limited the use of thrombectomy in simple iliofemoral thrombophlebitis to those cases without prior history of venous disease, and in whom symptoms are under four days duration, so that fresh clot which is relatively non-adherent to the vein wall can be removed readily and almost completely. We have not used this technique in the very elderly, in patients with cancer, or in patients with recurrent deep thrombophlebitis in whom clot cannot be easily evacuated due to chronic changes in the vein and valves.

These patients are all maintained on long-term anticoagulation and controlled compression stockings are worn for at least 12 months. It is advisable to continue these stockings indefinitely unless a subsequent venogram is entirely normal and the patient has no clinical evidence of venous insufficiency.

Some authors suggest that inferior vena cava clipping be included along with venous thrombectomy, and that control of the vena cava be obtained directly rather than through a contralateral occluding catheter. If the patient can tolerate general anesthesia, this has merits, especially if there has been a preoperative embolus.

Total or partial occlusion of the inferior vena cava by suture or clip technique is used for specific situations:

1. Those cases in which a patient has evidence of pulmonary embolus in spite of adequate anticoagulant therapy.
2. Cases in which anticoagulants are contraindicated.
3. In conjunction with venous thrombectomy or pulmonary embolectomy.
4. Those cases in which a previous massive pulmonary embolus has seriously threatened the patient's life and additional emboli might be expected to cause death.
5. Prophylactically in patients who are prone to venous thrombosis and in whom prophylactic anticoagulation is contraindicated, such as massive crush injuries to the lower extremity, or in association with an intra-abdominal procedure.

Ligation, rather than clipping, is reserved for recurrent multiple small emboli with progressive right heart failure or septic pelvic thrombophlebitis. Large collat-

erals develop after caval ligation which are capable of transporting lethal emboli. This has been documented by Gurevich[11] and ourselves by phlebography performed several months after ligation. In patients with clips, patency of the inferior vena cava has been demonstrated with little collateral formation. In the immediate postoperative period, the patient with a plastic clip has less problems with sequestration of fluid in the lower extremity and late sequelae are minimized[12] (Figs 6a and 6b).

The approach for a vena caval plication or clipping is relatively easy through a right flank muscle splitting incision similar to that used for sympathectomy. The transabdominal approach has been advocated in order that both ovarian veins can be ligated at the same time. However, we have been able to accomplish this through a flank incision. Should one wish to examine the left iliac vein closely in the case of possible obstruction secondary to iliac artery compression, the abdominal approach is, of course, necessary. The abdominal approach is easier but it incurs the increased morbidity of a formal laparotomy.

Following inferior vena cava clipping or ligation, the patient is fitted with leotard compression stockings and is ambulated slowly. Again, the patient is treated with heparin and long-term anticoagulation with coumarin type derivatives when not contraindicated.

Dextran[13,14,15] has not been found to have advantages over heparin and, therefore, has been reserved for those patients in whom anticoagulants are contraindicated. The basis for its use relies upon its ability to decrease the sludging effect, as well as platelet cohesiveness and adhesiveness. It may find more use as a prophylactic agent in such circumstances as hip fractures, which are associated with a high rate of thromboembolic complications. Phenindione (Hedulin®) and warfarin have been used in these circumstances with success.

There are many unresolved problems in the diagnosis and management of patients with the various manifestations of this disease process. With further experimentation and investigation, our approach to this problem may, of necessity, have to be modified. This review summarizes the current approach to the problem on the Vascular Service of the Medical College of Wisconsin (formerly Marquette) and of the Milwaukee County General Hospital.

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Psychosis and Other Psychiatric Manifestations of Levodopa Therapy

GASTONE G. CELESIA, MD and ARLENE N. BARR, MD, Department of Neurology, University of Wisconsin Medical Center, Madison, Wis: *Arch Neurol* 23:193–200 (Sept) 1970

Levodopa is an effective drug for the treatment of parkinsonism. However, mental disturbances occur not too infrequently during its administration. Sixteen of 45 patients receiving levodopa developed psychiatric phenomena. The psychiatric disturbances consisted of psychotic disorders in 8 cases; euphoria—4; acute anxiety—4; depression—2, and worsening of the basal mental status—5. Fourteen of the 16 patients, or 87.5%, had associated buccolingual or generalized dyskinesia. This association of psychic disorders particularly psychosis with buccolingual or generalized dyskinesia is characteristic of levodopa toxicity.

The levodopa psychosis-dyskinesia complex is reversible and most frequently controlled by diminution of levodopa dose. It occurs mostly in patients with associated organic brain syndrome or those suffering from postencephalitic parkinsonism. The levodopa psychosis-dyskinesia complex presents some fascinating similarities to other clinical entities such as Huntington's chorea, Wilson's disease, chronic manganese poisoning, and tardive dyskinesia secondary to phenothiazines.

The undesirable reactions to levodopa are interpreted as a combination of increased dopamine and dysfunction of the metabolism of norepinephrine, serotonin, and other amines. □

Mediastinoscopy

By V. Michael Miller, MD, Racine, Wisconsin

MEDIASTINOSCOPY is a method of exploration and biopsy in the superior and middle mediastinum, originally devised by Carlens[1] of Stockholm who reported his experience in over 100 patients in 1959 and established the technique as safe and useful.

This report contains the clinical experience with 159 patients in a private practice in Racine and Kenosha from 1964 to 1969.

Technique. The technique of Jepsen[2] and Palva[3] is used. Under general anesthesia a short transverse incision in the suprasternal notch is carried through the platysma muscle. The strap muscles are retracted and pretracheal fascia is opened by sharp dissection. The finger is then introduced along the anterior tracheal wall and advanced distally palpating for paratracheal nodes. Next, the long mediastinoscope is introduced and passed to the subcarinal region.The subcarinal nodes are then exposed with a long dissector. Thorough searching is done in the tracheobronchial and paratracheal regions. Suspicious tissue and nodes are biopsied.

Complications. One pneumothorax occurred in a patient with extensive chondrosarcoma in the mediastinum. This was easily managed with tube thoracostomy. No excessive bleeding occurred in this series.

Results. The series includes 159 patients, all without palpable cervical nodes.

Cancer. One hundred and three had intrathoracic cancer, 93 proven histologically and 10 definite clinically. All have been followed. Mediastinal node invasion was present in 34 of 103 (33%). Bronchoscopic biopsy provided tissue diagnosis in 20 of 103 (19%). Mediastinoscopy provided the only tissue diagnosis in 30 of 103 (29%).

Thirty-five patients with negative mediastinal biopsies underwent thoracotomy. Of these, 24 (70%) were resected for cure. False negative mediastinoscopy occurred in 4. In two, small intranodal metastatic foci were present in subcarinal nodes enlarged by prolonged obstructive pneumonia. In the other two, cancer was invading the aortic arch and lateral to the aortic arch, regions not readily accessible to the mediastinoscope.

The series includes 64 squamous, large cell, and adenocarcinomas of the lung, 15 oat cell or small cell carcinomas, 2 lymphosarcomas, 1 Hodgkin's disease, 1 chondrosarcoma and 7 metastatic cancers to the chest. All 15 small cell bronchogenic carcinomas metastasized to mediastinum.

Forty three were referred for cobalt therapy. In 22, mediastinoscopy furnished the only tissue proof of diagnosis.

In the entire cancer series 8 patients who seemed operable were spared thoracotomy. They had no definite signs or symptoms of remote metastasis, no bronchoscopic or radiographic signs of inoperability, and cardiopulmonary status was adequate to permit resection. Thoracotomy was not done because mediastinoscopy revealed positive mediastinal nodes.

Sarcoidosis. The series of 159 cases includes 17 patients with Boeck's sarcoidosis. Tissue confirmation was obtained in all cases that were clinically typical of sarcoidosis.

Miscellaneous. The remainder of the series includes such entities as unresolved pneumonia, massive pleural effusions, and enlarged hili. Cancer was suspected in all.

Discussion. Approximately one-third of lung cancer victims have metastatic cancer to paratracheal and subcarinal nodes when first seen. Even 20% of peripheral bronchogenic cancers have invasion of these nodes.[2] Biopsies can safely be obtained from both sides of the mediastinum and the subcarinal region through a single suprasternal midline incision.

Nohl[4] and Bergh and Schersten[5] have shown that in bronchogenic carcinoma with invasion of mediastinal lymph nodes four-year survival is less than 9% after surgical therapy. Paulson[6] found that survival following resection for epidermoid carcinoma in which mediastinal nodes are involved is 8% to 9% whether or not preoperative irradiation is given.

Surgical mortality rates vary from as low as 9.5% for 328 pneumonectomies and 4.2% for 425 lobectomies and segmental resections in all age groups reported by Paulson[7] to as high as 50% for pneumonectomies in 42 patients over 70 years of age reported by Ostergaard.[8] Assessment of risk is not scientifically satisfactory.[9] Morbidity associated with resection of functioning lung tissue concomitantly with the cancer in patients who usually have chronic obstructive pulmonary disease is frequently significant.

Morrison and Deeley[10] obtained a 6% four-year survival rate, and Guttmann[11] obtained a 11.5% four-year survival rate with radical radiotherapy when cancer was confined to the chest. It therefore seems reasonable to use radiotherapy rather than thoracotomy for lung cancer in otherwise operable cases if mediastinoscopy demonstrates metastasis.

Perinodal vs. intranodal involvement is significant. The survival rate is about 10 times better with intranodal metastases than with perinodal involve-

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ment.[6] Thus, small intranodal foci of cancer which are occasionally missed by mediastinoscopic biopsy do not have as dire a prognosis as the usual case with mediastinal metastasis.

Mediastinoscopy reduces the number of patients in whom resection is not possible at thoracotomy. Radinov[12] analysed data (nearly 50,000 cases reported by 87 surgeons) and described the non-resectability rate as 43%. Reynders,[13] in a review of literature, described the range of non-resectability as between 20% and 50%, and in his personal series it was 40%. In 86% of the non-resectable lesions mediastinal extension was the cause of non-resectability. Following the use of mediastinoscopy, Reynders reduced his non-resectability figures at thoracotomy from 40% to 10%. Pearson[14] reduced his from 23% to 6%. Sarin and Nohl–Oser[15] reduced the non-resectability rate after the introduction of mediastinoscopy to 6% (7 of 120). Exploratory thoracotomy without resection carries a mortality of 4% to 12%.[7]

If mediastinoscopy is negative and pulmonary resection would likely impose significant mortality or morbidity, exploratory laparotomy should be done prior to thoracotomy. Bell[16] demonstrated a 19% incidence of occult metastasis to liver, adrenal glands, and abdominal lymph nodes. Yashar[17] found hepatic metastasis in 15% of lung cancer cases explored through the diaphragm. Splinting of respiration and impairment of cough after upper abdominal incision[18] makes a few days delay between a right abdominal incision and left thoracotomy advisable.

Approximately 15% of bronchogenic carcinomas are of the small cell type. These small cell or oat cell bronchogenic carcinomas are so notoriously malignant that thoracotomy is contraindicated if this histological diagnosis can be established prior to thoracotomy. A British Medical Research Council[19] in random fashion compared 71 operable cases treated with surgery to 73 operable cases treated by radiation therapy. There were no survivors of operation at five years and 3 (4%) survived five years after radical irradiation without evidence of disease. Fortunately, small cell carcinomas usually metastasize to the superior and middle mediastinum, a region accessible to the mediastinoscope. In this series, 15 of 15 (100%) mediastinoscopies were positive, and Sarin and Nohl–Oser[15] found 65 of 90 (75%) positive.

Mediastinoscopy is of value in securing tissue diagnosis of intrathoracic cancer when bronchoscopy does not. It is of value in differential diagnosis of mass lesions in the chest. One patient in this series had a 3 cm soft peripheral lesion which diminished slightly in size on tuberculosis chemotherapy. He was a poor candidate for lobectomy. Mediastinoscopy revealed bronchogenic carcinoma and he was spared thoracotomy. Tissue diagnosis is of particular value to the radiotherapist. It furnished the only histological diagnosis in one-half of the patients in this series who were irradiated.

Mediastinoscopy usually provides tissue confirmation of Boeck's sarcoidosis. In this small series, 17 of 17 (100%) were positive. Most series in Jepsen's[2] review were positive in 96% to 100% of cases. The diagnostic yield in sarcoidosis is lower with scalene biopsy. Foti and Moser[20] reported 36 of 40 (90%) positive scalene biopsies and 15 of 20 (75%) positive liver biopsies. However, they did not mention whether nodes were palpable. Lofgren *et al*[21] found 173 of 194 (89%) positive when nodes were palpable but only 15 of 47 (32%) when nodes were not palpable. Mortality, morbidity, and hospital stay with mediastinoscopy are comparable to scalene fat pad biopsy. General anesthesia is necessary for mediastinoscopy but no damageable vital structures are encountered if the correct technique is used[2] whereas phrenic nerve, thoracic duct, subclavian and jugular veins, and pleura are encountered in thorough scalene fat pad excisions. If pulmonary involvement were present in a keloid former, I would advocate a short inframammary incision and lung biopsy rather than the short suprasternal incision.

Conclusion. Mediastinoscopy is a safe and useful tool in diagnosis and management of intrathoracic cancer and Boeck's sarcoidosis.

The procedure is advocated for (1) all operable bronchogenic carcinoma patients, and (2) those inoperable patients with intrathoracic lesions suspected as being cancer in whom simpler diagnostic methods fail to give a histological diagnosis.

Radiotherapy, not thoracotomy, is advocated for all otherwise operable patients with mediastinal node invasion because survival rates following radiotherapy are comparable to those of resection and functioning lung tissue is not removed.

Mediastinoscopy will obviate some unnecessary thoracotomies.

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Emphysema with Hereditary Alpha-1 Antitrypsin Deficiency Masquerading as Asthma

S. MAKINO, MD; LOUIS CHOSY, MD; ENRIQUE VALDIVIA, MD, and CHARLES E. REED, MD, University of Wisconsin Medical School, Madison, Wis: *J Allerg* 46:39–47 (July) 1970

Ten patients among 11 persons homozygous for hereditary $alpha_1$-antitrypsin deficiency had chronic obstructive lung disease with exertional dyspnea as the prime symptom. Some also had wheezing and sputum production. Early in the course of the illness five of the patients were erroneously considered to have asthma. One patient was unique, lacking detectable levels at all. Assay of serum of family members was consistent with an autosomal codominant mode of inheritance in all families. Autopsy of the two patients who died showed extensive panacinar emphysema. One had in addition peribronchial inflammation, extensive squamous metaplasia of the tracheal and bronchial epithelium, and distinct degencrative changes of the tracheobronchial cartilage plaques. □

Natural History of Recurrent Bacteriuria in School Girls

C. M. KUNIN, MD, VA Hospital, Madison, Wis: *New Eng J Med* 282:1443–1447 (June 25) 1970

A long-term study of recurrent bacteriuria was carried out in girls in whom urinary-tract infection was detected during school surveys. In most of them management was limited to short-term, specific chemotherapy coupled with frequent follow-up examinations. Eighty percent of recurrences were due to reinfection with a new organism. Each course of therapy extracted 20 to 25 percent of white and about 40 percent of Negro girls into long-term remission. Recurrences in the population closely followed a logarithmic decay curve, which demonstrated the marked effect of age and race. Socioeconomic status and vesicoureteral reflux had no significant effect on recurrence rates. Recurrences tended to be less frequent the longer the girls remained free of infection, but they were still at higher risk of acquiring bacteriuria than the general population. Marriage and pregnancy were times of increased risk. □

Diminished Renal Urate Secretion per Nephron as Basis for Primary Gout

R. E. RIESELBACH, MD; L. B. SORENSEN, MD; W. D. SHELP, MD, and T. H. STEELE, MD, University of Wisconsin Medical School, Madison, Wis: *Ann Intern Med* 73:359–366 (Sept) 1970

In order to examine the role of the kidney in the pathogenesis of primary gout, 15 gouty patients were studied with regard to rate of uric acid turnover and renal transport parameters. Uric acid turnover data from 9 control subjects provided the basis for classifying gouty patients as either overproducers or normoproducers. Utilization of the pyrazinamide suppression test allowed comparison of renal rates of urate reabsorption and secretion with previously published data in normals and between the two groups in the presence of both endogenous hyperuricemia and allopurinol-induced normal levels of plasma urate.

A discrepancy of urinary urate excretion was apparent upon comparing the two groups during hyperuricemia. Both groups displayed a normal pattern of urate reabsorption over a wide range of filtered loads. However, while the pattern of urate secretion in gouty overproducers could not be distinguished from previously published data in normals, diminished urate secretion was evident in normoproducers during hyperuricemia and is the basis for their observed decrease in urinary urate excretion.

Thus, normoproducers display a defect in urate secretion which becomes progressively more apparent as the P_{ur} increases. It is suggested that this insufficient secretory response to hyperuricemia imposes a limitation upon the capacity for urate homeostasis in the presence of normal variations in production of uric acid, and thereby provides the basis for hyperuricemia in some patients with primary gout without demonstrable overproduction of uric acid. □

NEW DRUG RESEARCH: Sulpiride

Sulpiride: Produced favorable results in 90% of patients with peptic ulcer. Vomiting and pain disappeared and the duration of acute attacks was sharply reduced. The drug is a neuroleptic agent. By Drs. G. Albot and J. Boisson, Paris.—AMERICAN DRUGGIST, October 19, 1970 □

False Elevations of Serum Glutamic-Oxalacetic Transaminase Due to Para-aminosalicylic Acid

KEVIN P. GLYNN, MD; ANTHONY F. CAFARO, MD; CURTIS W. FOWLER, MD, and WILLIAM W. STEAD, MD, Muirdale Sanatorium and Department of Medicine, Marquette School of Medicine; and Department of Pathology, St. Joseph's Hospital, Milwaukee, Wis: *Ann Intern Med* 72:525–527 (April) 1970

Para-aminosalicylic acid (PAS) in serum has been shown by in vivo and in vitro studies to induce false elevations in serum glutamic-oxalacetic transaminase (SGOT) level as determined by the colorimetric method commonly used in automated analyzers. This does not appear to reflect any hepatic injury, and no changes have been found in SGOT levels determined by the specific reduced nicotinamide adenine dinucleotide (NADH)-linked method of Karmen, or found in serum glutamic-pyruvic transaminase (SGPT), or in serum lactic acid dehydrogenase (LDH) levels. As the use of multichannel analyzers becomes more widespread, more reactions of this type will be observed in patients receiving other drugs. □

Acetylsalicylic Acid-Induced Hemolysis and Its Mechanism

N. T. SHAHIDI, MD and D. W. WESTRING, MD, University of Wisconsin Medical School, Madison, Wis: *J Clin Invest* 49:1334–1340 (July) 1970

Acetylsalicylic acid (ASA) is known to induce severe hemolysis in some glucose-6-phosphate-dehydrogenase-deficient (G-6-P.D.-deficient) individuals. To study its mechanism, erythrocytes from a seven-year-old boy with extreme sensitivity to ASA were transfused to a normal compatible recipient. The administration of 150 mg/day of 2,5 dihydroxybenzoic (gentisic) acid, a known ASA metabolite with redox properties, to the recipient resulted in a 50% decrease in the survival time of the patient's erythrocytes.

Similar studies with red cells from individuals with A- and Mediterranean variants of G-6-P.D. resulted in no alteration in the erythrocytes' survival. Incubation of the patient's erythrocytes with sodium gentisate (6mM) resulted in 27% methemoglobin and a 60% decrease in GSH at the end of two hours. Similar studies with erythrocytes from an A-variant resulted in 12% methemoglobin and 40% decrease in GSH. Salicylate (10mM) alone exhibited no oxidative properties, but it markedly enhanced the gentisate-induced hemoglobin and GSH oxidation in the patient's erythrocytes.

Kinetic studies with partially purified G-6-P.D. from erythrocytes and, in some instances, fibroblasts from the patient, four normal individuals, two A-variants of G-6-P.D. and two Mediterranean variants revealed that in all instances sodium salicylate (10mM) inhibited the G-6-P.D. by competing with NADP. However, while the change in $K_m(K_p)$ in individuals with A- and Mediterranean variants (refractory to therapeutic doses of ASA) did not significantly deviate from the normal, the K_m for NADP of the patient increased from 17.6μM to an extremely high value of 123μM. Gentisic acid was found in all instances to be a more potent inhibitor in that 5mM produced an apparent change in K_m similar to that obtained with 10mM of salicylate.

The above studies suggested that enzyme inhibition by salicylate and gentisate plays an important role in ASA-induced hemolysis. □

Accuracy of Sphygmomanometers in Hospital Practice

L. V. PERLMAN, MD et al, Milwaukee County General Hospital, Milwaukee, Wis: *Arch Intern Med* 125:1000–1003 (June) 1970

Three hundred ten aneroid and 25 mercury sphygmomanometers in hospital use were calibrated against a new mercury manometer standard which properly recorded zero. A total of 68.4% (212 of 310) of the aneroid instruments and all of the mercury instruments were accurate with ± 3 mm Hg tolerance (average of four readings). An average deviation from standard of greater than ± 7 mm Hg was shown by 13.2% (41 of 310) of the aneroid instruments. Significant variation among hospitals in the proportion of accurate aneroid manometers appeared to be related to maintenance procedures. Aneroid sphygmomanometers must be calibrated periodically against a mercury manometer standard with a simple Y-tube connection. Only with careful observation, calibration, and maintenance should aneroid instruments be used in emergency care situations or in scientific studies concerned with indirect blood pressure. □

Obscure Hemolytic Anemia Due to Analgesic Abuse

E. A. AZEN, MD et al, University of Wisconsin Medical School, Madison, Wis: *Amer J Med* 48:724–727 (June) 1970

Three patients are described with acquired hemolytic anemia due to surreptitious analgesic drug abuse. They denied exposure to drugs, but metabolites of para-aminophenol analgesic derivatives were found in the urine. Analgesic drug abuse should be suspected in patients with obscure acquired hemolytic anemia, even when a history of drug exposure cannot be obtained, but especially when the patient has chronic pain and appears neurotic. Methemoglobinemia and an increased number of erythrocytes with Heinz bodies are not always present. If this problem is suspected, and especially when the diagnosis of "enterogenous cyanosis" is being considered, the urine should be examined for the presence of NAPA (N-acetyl-para-aminophenol). □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Professor of Clinical Pharmacology, Medical College of Wisconsin, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

The Oral Hypoglycemic Agents

By Edgar S. Gordon, MD, Madison, Wisconsin

THE ORAL HYPOGLYCEMIC DRUGS were developed originally with the hope that they might serve as "oral insulin," thereby eliminating the tedious chore of daily injections that plague the lives of so many diabetic patients. It soon became apparent, however, that these compounds would not substitute for insulin in true insulin dependent diabetics. It is now well accepted that their major usefulness occurs in those diabetic subjects who have not lost their ability to produce and release into the blood a significant amount of insulin.* From the clinical standpoint, "essential" diabetes may be subdivided into three major categories: (1) juvenile, childhood onset, insulin dependent disease which is a true insulin deficiency, characterized by weight loss, keto-acidosis leading to coma, exceedingly low blood insulin concentrations and obligatory dependence upon insulin administration, (2) adult onset type, usually accompanied by obesity, absence of weight loss, absence of keto-acidosis, and elevated concentrations of insulin in the blood, if compared with non-obese subjects, and (3) the intermediate category of diabetes, most commonly seen in elderly patients, in which there is usually weight loss; and the capacity to produce and release insulin is lost to a lesser or greater extent. Tendency to develop ketosis is slight or moderate and acidosis usually does not occur. Such patients may require insulin for adequate metabolic control.

Detailed discussion of these three categories of disease is clearly outside the scope of this brief report, but the classification is important since the differentiating features of the three types form a rational basis for judgment in the use of oral hypoglycemic agents.

The only clearly demonstrable and generally accepted mode of action of the sulfonyl urea compounds is their capacity to increase the rate and amount of insulin released from the beta cells of the pancreatic islets. In terms of practical therapy, this fact excludes for the most part, the use of these compounds in juvenile diabetes, since the magnitude of the metabolic defect is too large to be treated by any means other than substitution therapy with insulin. The second type of disease often is accompanied by marked hyperglycemia, at times exceeding 400 mg/100 ml despite which ketosis rarely occurs. It is generally believed that the cause of this striking hyperglycemia and the hyperinsulinemia as well, is resistance to the physiological action of insulin caused by the excessive accumulation of adipose tissue. The defect becomes greater as obesity increases and improves progressively as body weight is reduced, and sensitivity to insulin returns. Therefore, imposition of a low carbohydrate, low calorie diet is the best therapeutic measure, and it may be expected to improve significantly the blood glucose level. Use of an oral hypoglycemic agent will often produce further improvement. Not only is insulin unnecessary but also it is actually contraindicated in this type of disease since high concentrations are already circulating in these patients.

See editorial, "The Great Tolbutamide Controversy," on page 48.

Oral agents often achieve their maximum usefulness in the third type of diabetes. A substantial proportion of these patients will have modest to moderate hyperglycemia, often with positive urine tests, as the only manifestations of their disease. The use of insulin, even in small dosage, is undesirable since many of these patients are in an advanced age group when the learning of insulin technique is very difficult due to poor eye sight and general debility. The addition of an oral hypoglycemic agent may suffice to correct the hyperglycemia enough to produce negative or at least satisfactory urine tests and maintain normal body weight and vigor. As a rule of thumb it may be stated that the presence of ketosis in a diabetic subject on diet alone usually indicates that insulin will be needed.

The contribution of oral hypoglycemic agents to the comfort, state of health, and longevity of diabetic patients has been a controversial subject since their introduction. In the management of juvenile

*The present discussion specifically excludes phenformin (DBI®) from consideration since its mode of action is completely different from that of the sulfonyl ureas.

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diabetes, some claims have been made that despite the unquestionable need for insulin, the oral agents have contributed some metabolic stability when added to the therapeutic regimen as a supplementary medication. The disagreement about this issue remains unsettled, but the majority of physicians does not use oral agents in this manner.

In obese, non-insulin dependent diabetics the hyperglycemia, even though it may be marked, usually is asymptomatic and probably not in itself dangerous. However, this point also is debatable and controversial. Does the use of oral agents under these circumstances contribute anything important to the welfare of the patient, or is the physician simply treating the blood glucose level? This question needs to be answered. The traditional indoctrination of both physician and patient, that the correct management of diabetes always attempts optimal normalization of blood glucose concentrations, is so powerful that a psychological compulsion demands the use of whatever measures are necessary to attain this goal. However, there is no general agreement that hyperglycemia is, per se, a liability if it is asymptomatic and is not attended by ketosis.

Thus the position of limited usefulness of the sulfonyl urea compounds in the treatment of certain types of human diabetes became well defined and generally accepted until its status became threatened recently by the now well publicized report of increased incidence of atherosclerotic complications, and specifically coronary heart disease, in patients using tolbutamide (Orinase®) as compared to those managed by diet alone.[1] This observation obviously was of such importance that it demanded further study leading either to confirmation or refutation. Therefore additional investigation was undertaken by the University Group for Diabetes Program (UGDP) supported by the National Institutes of Health. The final report of this group has only recently been published,[2] but its general content was known in advance since a preliminary report was given to the American Diabetes Association in June 1970. A storm of protest has been raised by a great many people within and outside the medical profession. Special criticism has been focused on the Federal Food and Drug Administration (FDA) which issued a half-hearted and ambiguous "warning" that none of the sulfonyl urea hypoglycemic agents should be used except as a last resort, and that these drugs should not be prescribed for chemical or latent diabetes, suspected diabetes, in prediabetes or in the presence of keto-acidosis.

It is not possible in a short report to discuss in detail either the content or the implications of these studies. The UGDP study is an important document, however, even though it probably raises more questions than it answers.[3] Three specific conclusions deserve brief further comment:

Although the original observations concerning the morbidity of coronary heart disease were focused specifically on tolbutamide, the FDA has classified all sulfonyl urea compounds together. This fact has raised a storm of protest since such a blanket condemnation cannot be justified on the basis of the available facts and because such action summarily removes all oral hypoglycemic agents (except phenformin—DBI®) from free clinical use.

The FDA statement is non-commital and provides no clear official policy for practicing physicians. Many of the latter, if they care to review critically the official report, may elect to continue use of these agents despite FDA recommendations, and in the event of cardiac complications (some of which are almost certain to occur in any diabetic of this age group) the ugly specter of medicolegal complications becomes a possibility.

The UGDP study, despite its careful design and the great effort expended in providing adequate controls, does not settle the basic issue which concerns the potential danger or safety of tolbutamide in the treatment of human diabetes. A great many experts in the field of diabetes have been vocal in expressing their dissatisfaction with the conclusions that have been published. It is apparent that the FDA is now obliged to take further action in an effort to resolve this important issue. All of this is disturbing to practicing physicians, for if the experts cannot agree among themselves, what chance does the less specially trained individual have in arriving at a satisfactory policy for himself.[2]

In conclusion, an expression of personal opinion by the author does not seem out of order. Based upon careful study of the evidence presented in the official UGDP study, it seems justifiable to state that there is currently not enough evidence of a significant liability to diabetic patients from the use of tolbutamide (and presumably the other sulfonyl urea hypoglycemic agents) to warrant eliminating these drugs from general use in the treatment of appropriate cases of diabetes mellitus. In addition to the expression of this personal view, it seems probable that the majority of American physicians treating diabetes—if an opinion poll could be taken—would support the continued use of these drugs. It is of interest in this connection that the Committee on Safety of Drugs of Great Britian in a recent action,[4] has not found it necessary to impose restrictions on the use of tolbutamide. Hopefully, further experience and possibly additional studies may clarify this issue and demonstrate more convincingly than at present the dangers of prescribing this compound, if indeed such a danger does exist.

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Severe Cardiomegaly with Porphyria

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It is the purpose of this paper to report a case with the largest heart for the age of the patient recorded in the literature. It is the only reported case of severe cardiomegaly associated with porphyria. The diagnosis of porphyria was not established clinically but rather at the time of the post-mortem examination.

Case Report. The patient was 23 years old when he died. In February 1967 a diagnosis of "cardiomyopathy" was made. At that time he had heart failure and acute paroxysmal tachycardia. The heart showed marked enlargement. The patient had indigestion and right upper quadrant pain which were more severe in the spring and summer.

Muscular atrophy developed over the ensuing three years. The patient had been evaluated at two other medical centers. The diagnosis remained as "cardiomyopathy" along with muscular atrophy.

The patient was jaundiced nine months prior to his present hospitalization. The icterus subsided somewhat shortly before he died. He also had severe dyspnea.

Physical examination showed a diffuse apical impulse and Grade 1 apical systolic murmur. There was edema of both legs and arms. His blood pressure was 100/74 mm Hg. There was no enlargement of the liver or spleen.

The red blood cell count was 6.41 million. The hematocrit reading was 55 and the hemoglobin was 17 gm/100 ml. The white blood cell count was 10,600 per cu mm with 85% segmented cells. The urinalysis showed a 1+ albumin. The 12–Channel multiphasic blood chemistry evaluation showed the SGOT to be 1600 units. The plasma urea nitrogen was 59 and the total bilirubin was up to 7.0 mg/100 ml. The alkaline phosphatase, carbon dioxide content, chlorides and blood ammonia were within normal limits. The potassium was up to 6.2 and the sodium was down to 127 mg/100 ml.

An x-ray film of the chest showed marked cardiac enlargement. The electrocardiogram was interpreted as demonstrating atrial fibrillation with a right bundle branch block. The patient died three days after he was admitted to the hospital.

Autopsy findings showed atrophy of the muscles. This, along with the neurological findings, suggested the possibility of a porphyria to the prosector. As the autopsy progressed, wine colored fluid was noted in the pericardial sac. There was no obvious explanation for this discoloration. Subsequently, similar findings were noted in the urinary bladder and also in the ascitic fluid. Chemical analysis of the urine revealed the presence of coproporphyrins and porphobilinogen. The latter is pathognomonic for intermittent hepatic porphyria.[1] The urine was negative for uroporphyrins. Porphobilinogen has been reported in hepatitis, carcinomatosis and cirrhosis, none present in this case.

The spinal cord showed advanced degeneration of the anterior horn nerve cells. Such findings are associated with porphyria. The mechanism of the nerve destruction is not known.

The abnormal liver function tests were attributed to the very severe passive congestion of the liver secondary to myocardial insufficiency. The elevated transaminase was secondary to the myocardial changes, the muscular dystrophy, and the severe congestion of the liver secondary to cardiac failure.

Elevated transaminase has been reported in porphyria associated with cardiomyopathy by Eilenberg.[2] His patient was admitted four times in one year as a psychiatric emergency. On the fifth admission, porphyria was diagnosed. There was a striking cardiac deterioration noted on the electrocardiogram. This improved with therapy. Eilenberg included four other references in which electrocardiographic changes were associated with porphyria. These reports predated the introduction of the transaminase determination.

The heart in our case was hypertrophied, weighing 1430 gm. There were no organic changes in the heart valves. There was some malfunction of the mitral and tricuspid valves secondary to the marked dilation of the right and left ventricles. The myocardium of both ventricles showed extensive fibrosis which was more pronounced in the left. There were a few lymphocytes in the scar tissue. The remaining muscle fibers showed advanced degeneration in some areas, especially in the left ventricle. The coronary vessels showed no atheromatous changes. The vessels were stretched over the large ventricles and, consequently, had narrowed lumens. One wonders how sufficient blood reached the myocardium through these stretched-out compressed vessels to keep the heart functioning, under the circumstances. The fibrosis is attributed to foci of necrosis secondary to anoxia. However, deleterious effects of porphyria must be considered as abnormal electrocardiograms are found with porphyria.[2] Also, porphyria may be associated with nerve damage, the mechanism of which is not known.

Discussion. A review of the literature indicates this to be the largest heart for a patient of this age that has been reported.

Cardiomyopathy, along with prolonged neuropsychiatric disability and elevated transaminase, has been associated with porphyria.[2]

Karatzas[3] reported four patients who had hypertrophic cardiomyopathy of unknown etiology. Two of the patients were monozygotic twins who were 24 years of age. A hereditary factor is certainly suggested when such an unusual condition occurs in

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twins. Acute intermittent hepatic porphyria is believed to be inherited as a Mendelian dominant characteristic. Porphyria is not always obvious and can be easily missed. The urine may appear normal and only darken on standing when the colorless porphobilinogen changes to porphobilin and uroporphyrin.

Levy[4] reported ten cases of cardiac hypertrophy of unknown cause. The largest heart was 740 gm in a patient 29 years of age. The ages of his patients ranged from 29 to 66 years. There was no typical angina in any of the ten patients. The changes in the electrocardiogram varied with the degree of fibrosis. There was no advanced arteriosclerosis in this series. There were small aggregates of lymphocytes. The valves, at most, showed only minimal changes. These findings were similar to these found in our case.

Evans and White reported 33 hearts that had massive hypertrophy. The largest was 1350 gm. The age was not given. This was associated with rheumatic heart disease. One case was classified as myocarditis of unknown etiology. The remainder had no pathological conditions to account for the hypertrophy.

Penna[6] reported on 15 hearts that weighed 1000 gm or more. One patient was 25 years of age and the heart weighed 1000 gm. The largest heart weighed 2000 gm. This patient was 43 years of age and had adhesive pericarditis. One of the patients was considered to have a mental disturbance. This may have been significant as undiagnosed porphyria may be present in psychiatric conditions.[2]

Golden[7] stated that there were only 38 instances of hearts that weighed 1000 gm or more in the literature up to 1937. All were associated with pathological conditions. Ten of the 38 were 25 years of age or younger. Stokes[8] reported the largest heart in this group. It weighed 1980 gm. The patient was a 25-year-old man who had repeated attacks of rheumatic fever with disease of the aortic valves and pericarditis.

Golden[7] found nine similar cases in the files of the Cook County Hospital between 1928 and 1937. All but one had significant pathological alterations to account for the hypertrophy. The heart, with insignificant changes, was also the largest of the nine cases they reported. This heart weighed 1475 gm and was from a colored man who was 33 years of age. There were insufficient clinical or pathological findings to account for this profound enlargement. This case is quite similar to our own.

Edington[9] discussed idiopathic cardiomegaly in detail. Hypertension, organic valvular disease, coronary artery disease, intra and extra cardiac shunt, obstructive cardiomyopathy, myocarditis, amyloidosis, and cor pulmonale must be excluded before this condition is diagnosed, in their opinion. None of these conditions was present in our case.

Rosenow[10] reported 44 cases with extreme cardiac hypertrophy from the files of the Mayo Clinic. Five of the hearts weighed more than 1000 gm. One weighed 902 gm in a 20-year-old patient who had aortic insufficiency. In two instances, the only positive finding was obesity. The weights of the hearts were excessive to be caused by obesity alone. The body weight in one was 550 lb and the heart weighed 929 gm. The second weighed 350 lb and the heart weighed 922 gm. Another patient had hyperthyroidism. The remainder had organic heart disease.

Strong[11] reported 42 cases in which the heart weighed 750 gm or more. In five instances the weight was more than 1000 gm. The largest was 1750 gm. The patients were between the ages of 39 and 51. There were no instances of idiopathic hypertrophy in his series.

Summary. The heart, in this case, weighed 1430 gm. It was from a 23-year-old man. This is the largest heart recorded for a patient of this age. There was no organic disease to account for the profound hypertrophy. It is the only case of severe cardiomegaly associated with porphyria recorded in the literature. Cardiomyopathy has been described in acute intermittent porphyria.[1] Therefore, porphyria could conceivably be a factor. Other instances of idiopathic cardiomegaly are referred to in the text. This condition was present in a pair of monozygotic twins. Their age was 24. Porphyria is believed to be inherited as a Mendelian dominant characteristic.

The patient in this report was not diagnosed as having porphyria until after his demise. The muscular atrophy and the appearance of the urine, ascitic and pericardial fluid, suggested the possibility of porphyria to the prosector. This was confirmed by chemical analysis. It is possible that others with cardiomegaly or cardiomyopathy are similarly overlooked.

Levy's[3] series of 10 cases of cardiomegaly of unknown etiology showed pathological findings similar to our case.

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Immediate Treatment of Myocardial Infarction

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IN RETROSPECT, it is clear that in the first 50 years after Herrick gave the first clinical description of acute myocardial infarction in 1912, negligible progress was made in therapy. The advent of coronary care units, electrical defibrillation, and preventive drugs more recently have considerably reduced the mortality of hearts too good to die. Nevertheless, very many patients die suddenly before reaching a hospital and a goodly number of these are preventable deaths.

There is now considerable interest in the prehospital phase of the heart attack. The purpose of this paper is to present and emphasize two simple interventions that can be used by a physician when he first sees any case of possible myocardial infarction, and which certainly should be used before an electrocardiogram is obtained and before the diagnosis is established. These medications, if given as we shall suggest, are so safe and so potentially life-saving that their use, with certain changes, could well be extended to ambulance drivers and nurses.

It is now generally accepted that many of the deaths in the early hours of myocardial infarction are due to electrical problems of the heart.[1] Increased ventricular irritability results in premature ventricular beats which may lead to a repetitive ventricular response or ventricular fibrillation.[2] Another important source of danger is a slow heart action (bradyarrhythmias)[3] which may be due to increased vagal tone.

The potential benefits of two drugs, lidocaine and atropine, are dramatically illustrated in two cases we have recently seen.

Case Reports

Case 1. The electrocardiogram (Fig 1) was recorded in a 44-year-old man with anterior chest pain and a history of a previous myocardial infarction. The three standard leads and lead aVR are shown. Q waves in leads 2 and 3, and the initial R wave in lead aVR, are the result of a previous inferior myocardial infarction. Elevated S–T segments in standard lead 1 indicate an acute anterior myocardial infarction. In lead 1, two premature ventricular beats occur, each beginning 0.35 second after the onset of the previous QRS (the coupling interval). In lead aVR, the first two premature beats have rather shorter coupling intervals, and the third has the shortest—0.28 second. This last extrasystole falls on the apex of the T wave—the vulnerable phase of the ventricle—initiates a repeated response which soon becomes ventricular fibrillation. This was later terminated by direct current countershock (not shown). This complication, potentially fatal, was entirely preventable by intramuscular or intravenous lidocaine.

Case 2. The electrocardiogram (Fig 2) was recorded in a 67-year-old man with severe and prolonged angina pectoris. In the upper section, a slow sinus mechanism (rate, 50 per minute) is present. This is either sinus bradycardia at 50 beats per minute, or a sinus rhythm at 100 beats per minute with every second complete cardiac cycle (PQRST) being dropped out due to a 2:1 sino-atrial block. The intravenous injection of 0.4 mg of atropine produced a sudden doubling (or near doubling) of the rate, and indicates that S–A block is the correct diagnosis. The lower strip shows 10:9 S–A block with the Wenckebach phenomenon, and shortly thereafter a regular sinus rhythm was recorded. Anginal pain disappeared with the change in rate and improvement in cardiac function.

Discussion

SUPPRESSION OF VENTRICULAR IRRITABILITY

Lidocaine is now the standard drug for the treatment of ventricular irritability in our Coronary Care Unit. It suppresses extrasystoles arising in ectopic

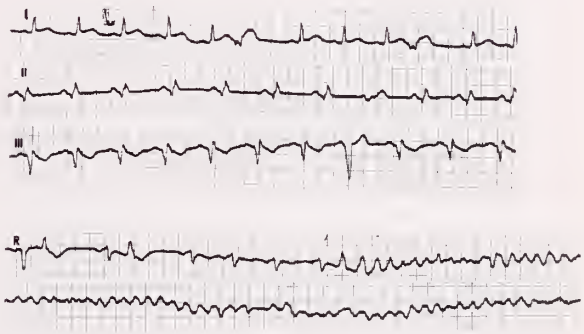

Fig. 1—Electrocardiogram on admission of patient in Case 1. There is evidence of an old inferior and an acute anterior myocardial infarction. Premature ventricular beats with slightly varying coupling occur. In lead aVR, one single ventricular extrasystole falls upon the vulnerable phase of the preceding beat and initiates ventricular fibrillation. This arrhythmia could have been prevented by early administration of lidocaine. See text.

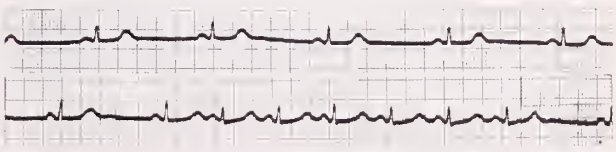

Fig. 2—Electrocardiogram (standard lead 2) of patient in Case 2, recorded during status anginosus. Second-degree sino-atrial block (2:1) is present in the upper strip, and is changed by atropine in the lower strip, with resulting abolition of the anginal pain. See text.

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ventricular foci in acute myocardial infarction. Such premature beats may cause fibrillation if they occur in the vulnerable phase of the ventricle (Fig 1). Lidocaine should be administered as soon as the diagnosis is reasonably entertained. It is unnecessary to wait for any proof or documentation of infarction. This drug will not seriously affect the prognosis if the correct diagnosis is something else, such as pericarditis, dissecting aneurysm of aorta, or pulmonary embolism. Lidocaine is further indicated for preinfarction angina or severe coronary insufficiency without necrosis because ventricular irritability is associated with ischemia. The intramuscular route is simple and practical until an intravenous infusion can be set up. It will provide adequate levels in 15 minutes and the action is prolonged.[4] The recommended dose for an average sized adult is 200 mg. Intravenous injection is mandatory if the patient has an irregular pulse due to premature ventricular beats or if ventricular tachycardia is present. The dose is 50 to 100 mg. An intramuscular injection can then help to control the heart until the patient is hospitalized and monitoring and continuous infusion is possible.

Contraindication to lidocaine therapy. Lidocaine should not be used when there is complete heartblock as it may suppress the only focus in the ventricle. Therefore, intramuscular lidocaine should not be given if the patient's pulse rate is 45 or less per minute. Atropine and isoproterenol are then used.

BRADY–ARRHYTHMIAS

A pulse rate of less than 60 beats per minute can be seen in two sets of circumstances. In one there is increased vagal tone (perhaps heightened by morphine). The slow rate is potentially dangerous because: (1) it may be hemodynamically inadequate and (2) ventricular extrasystoles are more likely if the rate is slow.[5] Fortunately this type is temporary and can be abolished by atropine given intravenously. In the other cases, the bradycardia is due to involvement of the SA node or the AV node in the infarction process. This is serious and atropine seldom helps. Isoproterenol (Isuprel®) and pacing are indicated. If the patient has suffered syncope due to the slow rate (Morgagni–Stokes–Adams attacks), the sooner an intravenous infusion of isoproterenol (1 mg per 500 ml of 5% dextrose in water) is started the better.

Therefore, it would be wise if the physician who first sees a patient with chest pain and a pulse of less than 60 per minute were to give atropine, 1 mg intravenously, as soon as possible. The subcutaneous and intramuscular routes for atropine administration should be avoided as they may cause initial slowing.[6] The risk of precipitating an acute attack of glaucoma is a possible contraindication.

Summary

Lidocaine should be used in the prehospital phase of acute myocardial ischemia as soon as the diagnosis is suspected. If the pulse is more than 45 per minute, 200 mg of lidocaine should be given intramuscularly. If the pulse is irregular, an initial bolus of 50 mg is given intravenously. It should be withheld if the heart rate is less than 45 per minute. If the rate is less than 60 per minute, 1 mg of atropine should be given intravenously. With pulse rates between 45 and 60 per minute both drugs are given. These two simple interventions may contribute immeasurably to the probability of survival of patients with acute ischemic heart disease in the crucial period between the first contact with a physician and admission to the Coronary Care Unit.

The usefulness of lidocaine and atropine during the in-hospital phase of acute myocardial ischemia is now proven. It is, therefore, realistic to assume that these drugs have at least an equal place in the early hours of ischemia where the need may be even greater. Lown[7] and Scott[4] have made similar suggestions for the use of lidocaine. Bondurant[8] suggested the use of atropine and lidocaine, but was hesitant to recommend them until monitoring during the early stages is possible and their effectiveness proven. While such evidence would be welcome, it appears to us that, if a medication is safe (given as we have suggested) and does an immeasurable amount of good, it is reasonable to advocate its use. Myocardial infarction has to be treated in its early phase and particularly before the diagnosis is established, if deaths due to preventable ventricular arrhythmias are to be avoided. It may take several years for statistical proof of the value of early therapy to be forthcoming. In the meantime, thousands of preventable deaths might be avoided.

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Intrauterine Diagnosis of Craniolacunia

A Case Report and Review of the Literature

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IN RECENT YEARS increased emphasis has been placed upon the intrauterine diagnosis of fetal diseases. The x-ray is frequently used in pregnancy for maternal bone measurements and estimations of fetal bone age. These same films could diagnose craniolacunia. The recognition of fetal craniolacunia is important because of the associated anomalies. The purpose of this report is to present a case of craniolacunia (Lückenschädel) diagnosed in utero, and to review the literature on this subject.

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Case Report. The patient was a 42–year-old Negro woman, gravida 12 para 7–4–8, whose expected date of confinement was June 26, 1968. Her prenatal course was unremarkable. The patient had taken no medications other than iron and vitamins and had experienced no illnesses. An intravenous glucose tolerance test done at 34 weeks gestation because of glycosuria was normal with the fasting, 2 and 3 hour blood glucose values of 95, 87, and 78 mg/100 ml respectively, the K value of 1.3, and plasma insulin values which were normal. None of the patient's previous children had diagnosed congenital anomalies. On July 11 the patient was admitted to Jackson Memorial Hospital because of premature rupture of the membranes and this was confirmed by a vaginal cytologic test. The fetal heart rate was normal. X–ray pelvimetry was obtained the following day in anticipation of induction of labor. These films disclosed the typical roentgenologic findings of fetal craniolacunia (Fig 1). On July 12 the fetal heart was not heard. An intravenous oxytocin induction of labor was begun and after a total of 1 hour and 30 minutes the patient delivered a deformed stillborn male infant weighing 2450 gm and measuring 44 cm crown–heel. The umbilical cord had 3 vessels.

A roentgenogram of the stillborn infant was taken (Fig 2). Autopsy findings revealed multiple congenital anomalies. These included the craniolacunia skull, spina bifida with a lumbar myelomeningocele, bilateral

Fig. 1—X-ray pelvimetry showing the bony defects in the fetal skull which are diagnostic of craniolacunia (Lückenschädel).

club feet, atrial septal and ventricular septal defects, patent ductus arteriosus, and two small connections between the aorta and pulmonary artery, undescended testicles and bilateral cataracts. The mother had an abdominal tubal ligation performed on the fifth day postpartum. Her postoperative course was unremarkable and she was discharged home six days later.

Discussion. In 1874 Hoffman[1] first described this skull deformity, and in 1905 Engstler[2] termed it "Lückenschädel." Since then other synonyms have been used but most authors today use the term craniolacunia. The incidence of this skeletal anomaly is 0.94%.[3] Two forms of the condition have been described: (1) craniolacunia which is characterized by defects of the inner table surface of the cranial bones and (2) craniofenestria which is characterized by defects of both the inner and outer cranial layers. This latter type is clinically palpable as it places the dura in contact with the periosteum. The defects are usually limited to the thickest portions of the skull, therefore being found in the frontal, parietal, and upper occipital bones.[4] The lacunae begin to close about the time of birth and are usually unrecognizable by the age of 4 to 6 months.[5] Doorn and Boet[6] have reported the persistence of defects up to 17 years of age.

Fig. 2—X-ray of the stillborn infant. The "hammered silver" lacunar skull and spina bifida skeletal defects can be seen.

Three etiologies for this condition have been suggested: increased intracranial pressure, a genetic defect and environmental teratogens.[7, 8, 9] Since the cranial vault begins to ossify at eight weeks of gestational age, etiologic factors would need to be operating early in the pregnancy.[5] Several authors have refuted the pressure theory of etiology.[4, 6, 7, 10] The most widely accepted theory today is that of a genetic developmental bone defect which is often found in association with other anomalies.[10, 11, 12]

The association of other congenital abnormalities in infants with craniolacunia has been stressed by most authors. Common associated anomalies are spina bifida and myelomeningocele. Vogt and Wyatt[13] reviewed 6000 pediatric skull x-ray films, and in 120 cases with meningocele they found a 43% incidence of craniolacunia. The infants with both anomalies had a poorer prognosis than the ones having a myelocele alone.[13] Shopfner and associates[12] have reported a 50% incidence of craniolacunia in 179 patients with myelomeningocele and encephalocele. Other investigators[5] have confirmed this finding. Patients with craniolacunia also frequently develop hydrocephalus due to a stenosis of the aqueduct of Sylvius and/or an Arnold–Chiari malformation.[4] Other reported associated anomalies have included diastematomyelia, dextrocardia, inguinal hernia, dislocated hips, clubfeet and squint.[3,5, 11, 13] The present case demonstrates the multiple congenital anomaly syndrome involving particularly the skeletal, nervous, and cardiovascular systems. No teratogenic factors were recognizable in this patient.

In 1934 Maier[14] reported the

first two cases of craniolacunia diagnosed antenatally. Subsequently three other reports of the antenatal diagnosis have been published. [3, 5, 15] It is interesting that a condition which occurs so frequently (approximately 1%) is so seldom recognized in utero. Since the diagnosis is so simple if an x-ray film of the fetus is available, and since the associated congenital anomalies are so serious, it is important for the obstetrician to search for this condition when he is reviewing fetal roentgenograms. In certain situations the recognition of this condition may affect the obstetrical management. Finally, if the obstetrician has diagnosed fetal craniolacunia, it is important for him to closely examine the neonate for the other anomalies.

Summary. A case report of craniolacunia diagnosed in utero is presented, and the literature on this problem is reviewed. The prenatal diagnosis of craniolacunia should be attempted. An awareness of the high incidence of other associated congenital anomalies is stressed.

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Role of Child Psychiatry in Divorce

J. C. WESTMAN, MD, et al, Madison, Wis: *Arch Gen Psychiat* 23:416–420 (Nov) 1970

The likelihood that one out of six children in the United States has experienced divorce indicates that divorce is a family matter and focuses attention on the third party to the marriage contract: the offspring. This report describes the impressions of divorce gained from the perspective of child psychiatrists working in both a family court and a child psychiatry clinic.

Review of a consecutive series of divorces in a family court disclosed that 70% involved children. The incidence of post-divorce action legal contests was ten times higher for divorces involving children than for those that did not. The findings further indicated that divorce did not terminate the marriage conflict for one-third of the divorced couples with children. In these cases the divorce did not produce the expected benefit, irrational factors continued, and the affected children were in a turbulent situation.

The post-divorce cases with continued conflict showed four major patterns: (1) in some cases after divorce the parents appeared to continue the same conflicts and relationships that existed before; (2) in other situations the post-divorce conflict was child-centered in origin, the children appearing to manipulate the parents in order to perpetuate continued conflict or promote reunion of the parents; (3) another pattern was found in which one parent and a child conspired to produce an effect on the other parent, and (4) the final pattern confirmed the popular image of "meddling in-laws" in which the perpetuation of post-divorce turbulence appeared to arise from the influence of relatives.

A comparable consecutive series of cases in a child psychiatry clinic was studied, and 15% were found to have experienced divorce at some point in their lives. When related to the family court findings, the child psychiatry cases appeared to come from situations similar to the one-third of the family court cases with post-divorce turbulence, but not from divorces with reasonably implemented settlements.

This study conceptualizes divorce as a *process* rather than as an *event* and as a family matter with impact beyond the divorced couple. Professionals encountering divorce are well advised to recognize that (1) the need for professional support does not cease with the divorce decree in many instances, (2) an effort should be made to help divorcing parties openly recognize and face the realistic reasons for the divorce, (3) the children's interests should be foremost in determining custody and visitation arrangements, (4) a stormy divorce course often indicates continuation of marital conflict with the children participating directly or indirectly, and (5) the tendency of children to infer inordinate responsibility on their part for the divorce is reduced by their understanding of the realistic reasons for their parents' divorce. □

COMMENTS ON TREATMENT

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Therapy of Viral, Mycoplasmal and Rickettsial Infections

By Michael W. Rytel, MD and J. Donald Coonrod, MD, Milwaukee, Wisconsin

"TRUE VIRUSES" COMPRISE infectious agents containing only one type of nucleic acid (RNA or DNA), which replicate exclusively intracellularly and are not sensitive to the usual antibiotics. At present, only a handful of chemotherapeutic agents are of proven value in the prophylaxis or treatment of viral infections in man. The lack of clinically useful compounds is mainly due to the fact that measures which are effective in suppressing viral replication also affect the metabolic activity of the infected cells to varying degrees. Many chemical agents such as mitomycin C, actinomycin D, p-fluorophenylalanine and puromycin, possess a broad spectrum of antiviral activity *in vitro* but are simply too toxic to be employed for therapy in man. Others, like hydroxybenzyl—benzimidazole (HHB) anl guanidine, which are not particularly toxic, have not been found effective against experimental infections *in vivo*. This is probably due to the ready emergence of drug resistant viral mutants. Thus, only three types of antiviral drugs are available for clinical use: thiosemicarbazones, halogenated pyrimidine nucleosides, and amantadine (summarized in Table 1).

The Pox Viruses—Vaccinia and Variola

Progressive generalized vaccinia, vaccinia gangrenosa and eczema vaccinatum are rare but life threatening complications of smallpox vaccination which may occur, particularly in patients with impaired immune mechanisms or in those with eczema or burns. It has been demonstrated that methisazone (N-methylisatin-β-thiosemicarbazone) or Marboran® is lifesaving in patients with these complications.[1, 2] It acts by suppressing synthesis of the "late" structural proteins of the virus. An initial oral dose of 200 mg/kg followed by 50 mg/kg, at six hourly intervals for eight doses, is recommended. Because of its antiviral action against vaccinia, methisazone was also tested for its prophylactic activity against smallpox. It was reported in one study that among 1,101 close contacts of smallpox patients who were given treatment, there were only 3 mild cases of smallpox; while in 1,126 untreated contacts, 78 developed smallpox and 12 died. It was found that treatment was also effective in those contacts who had never been vaccinated.[3] Unfortunately, even though its efficacy in prophylaxis of variola has been demonstrated, methisazone does not appear to have any effect on the established disease. The drug is relatively nontoxic; the reported side-effects have consisted of occasional nausea, vomiting, and diarrhea.

Influenza A_2 Viruses

Amantadine (1-adamantanamine hydrochloride) or Symmetrel® appears to be an effective *prophylactic* agent against influenza A_2 virus infections, even though no drug effective in the therapy of influenza is presently available. Initial *in vitro* studies showed this synthetic salt of a symmetrical primary amine to be inhibitory against strains of influenza A_1 and A_2, but ineffective against other myxoviruses. This compound has been postulated to act by blocking viral penetration of host cells by steric interference. When amantadine was tested in a number of volunteer studies[4] and during naturally occurring epidemics of influenza A_2,[5] an appreciable decrease in the incidence of the clinical disease and subclinical infection was reported. There was also a significant amelioration of symptoms and signs in clinical cases. The prophylactic use of amantadine appears indicated during documented influenza A_2 epidemics in closed populations such as those of schools or prisons. The drug should be started as soon as possible following a known exposure and continued for 10 to 90 days. Amantadine is administered to adults in a single daily dose of 200 mg or in two equally divided doses, and should not be given to pregnant women. Children one to nine years of age are given a daily dose of 2 mg to 4 mg per pound of body weight (not to exceed 150 mg per day). The narrow range between the therapeutic and toxic dose of

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amantadine seriously limits its usefulness. Reactions have been reported with doses of 300 to 400 mg per day. Reported side-effects have included such central nervous system symptoms as dizziness, confusion, inability to concentrate and psychotic reactions. Geriatric patients who theoretically could benefit most from the prophylaxis with this drug (particularly nursing home inhabitants) are especially prone to develop these side-effects. Because of its serious side-effects, narrow spectrum of activity and limited indications, the role of amantadine in the antiviral armamentarium will probably prove to be quite small.[6]

Herpesviruses—Herpes Simplex, Varicella/Zoster and Cytomegaloviruses

Herpesvirus hominis is responsible for a number of clinical syndromes including "fever blisters," keratitis, and encephalitis, Idoxuridine (IDU, 5-iodo-2-deoxyuridine) or Stoxil® is available and effective for at least some clinical herpetic infections. Initially, it was shown to have antiviral activity against several DNA viruses when tested in tissue culture and in experimental animals. It acts by competitively inhibiting the incorporation of thymidine into viral DNA. Double blind trials have established the clinical efficacy of this compound in the treatment of herpetic keratitis.[7] One drop of idoxuridine 0.1% ophthalmic solution is placed in each infected eye every hour during the day and every two hours at night until definite improvement has taken place. The dosage may then be reduced to one drop every two hours during the day and every four hours at night. The therapy should be continued for three to five days after healing appears to be completed. Idoxuridine also can be given as an ointment instilled inside the conjunctival sac approximately every four hours, with the last dose being given at bedtime. The duration of therapy is similar to that of the ophthalmic solution. Applications of IDU ointment in the treatment of labial herpes have been generally unsuccessful, probably because of insufficient penetration of the drug to the site of viral replication. This difficulty, according to a recent study, may have been overcome by the use of a mechanical jet injector.[8] The treatment of herpes simplex encephalitis with intravenously administered IDU has been reported. In the most comprehensive study to date, Lerner and his colleagues reported that four of the six patients given IDU intravenously recovered and have resumed their normal activities.[9] The number of patients in this series is too small to prove the efficacy of intravenous IDU in this disease. However, because of the high incidence of mortality in untreated patients, the authors concluded that it may be indicated in some patients with life-threatening herpes encephalitis.

Cytosine arabinoside is another antimetabolite that has received attention as a possible antiviral agent. It is a pyrimidine nucleoside analog which selectively interferes with DNA synthesis and has been used in therapy of leukemias. Beneficial effects with this drug have been reported in therapy of congenital cytomegalovirus infections[10] and in disseminated herpes zoster.[11] Since cytosine arabinoside appears to be less toxic than IDU on parenteral administration, these preliminary studies are quite encouraging and may lead to an eventual use of this compound in life-threatening infections with certain DNA viruses. Most of these therapeutic approaches are still experimental and should be undertaken only by qualified investigators.

Immune Serum Globulins

Immune serum globulin (ISG) ("gamma globulin") is prepared from pooled human plasma by Cohn fractionation. ISG contains immunoglobulin-G antibodies concentrated about 15 to 25 times over the original plasma level. Because of the ever increasing number of effective vaccines, the indications for ISG have been steadily diminishing. Presently, immune serum globulins are of unquestioned value in only four viral infections: measles, infectious hepatitis, vaccinia, and variola. The role of ISG in mumps and rubella is more controversial, but will be discussed briefly (see Table 2 for dosages and preparations). When live attenuated vaccines were introduced, ISG was recommended for administration with them to decrease the attendant fever and rash. The currently available more attenuated Schwartz and Moraten vaccine preparations do not require administration of the globulin. The efficacy of gamma globulin in infectious hepatitis ("virus A" hepatitis) but not in serum (or "virus B") hepatitis has been well documented and consequently is a useful prophylactic procedure. It should be employed in individuals going into endemic areas. In complications of smallpox vaccination such as eczema vaccinatum and generalized vaccinia, and in prophylaxis following exposure to smallpox by nonimmune individuals, vaccinia immune globulin (VIG) may be useful, either alone or in conjunction with methisazone therapy. Mumps hyperimmune globulin may have a role in protecting susceptible postpuberal males against orchitis, although its efficacy has not been confirmed in a controlled study. In rubella, ISG will protect the recipient against clinical illness[12] but not against infection. It has been shown that administration of ISG to suceptible mothers in the first trimester of pregnancy will not prevent fetal damage. Since administration of ISG may lead to sensitization, its indiscriminate use is to be condemned.

Interferon

Presently, interferon is an attractive approach to prophylaxis and therapy of viral infections in man; however, it is not yet available to practicing physicians. Interferon is a substance synthesized *in vitro* and *in vivo* by virus-infected cells; it also may be released from intracellular storage *in vivo* by certain nonviral products. Interferon differs from specific

TABLE 1—*Antiviral Agents Currently Available for Clinical Usage*

Agents	Efficacy in Following Clinical Infections
Thiosemicarbazones (methisazone)	Vaccinia Variola
Halogenated Pyrimidine nucleosides (Idoxuridine—IDU)	Herpes Simplex
Amantadine	Influenza A_2

TABLE 2—*Dosages of Immune Serum Globulin in Prophylaxis of Selected Viral Infections*

Infection	Dosage
Measles	0.1–0.2 ml/lb (Prevention) 0.01–0.04 ml/lb (Modification)
Infectious Hepatitis	0.02–0.06 ml/lb
Rubella	0.25 ml/lb
Mumps	0.1 ml/lb*
Vaccinia, Variola	0.6–1.2 ml/Kg*

*Hyperimmune human gamma globulin.

immunoglobulin antibodies because it has a broad range of antiviral activity and induces in host cells a state of resistance to viral infection. Voluminous animal data has clearly established the efficacy of interferon, both exogenously administered and endogenously stimulated. Similarly, studies in man have demonstrated that volunteers pretreated with subcutaneous injection of monkey kidney interferon were protected against vaccinia virus inoculated at the same site.[13] Presently, it is virtually impossible to produce large enough quantities of interferon from *in vitro* tissue cultures to consider its exogenous administration to man. Consequently, most investigators have focused on the development of inducers of endogenous interferon production in the intact host. Working with the late Dr. Richard Shope, one of us (MR) has found that an antibiotic-like antiviral substance derived from *Penicillium funiculosum* mold (and named Helenine), exerted its effect through stimulation of interferon response *in vivo*.[14] The isolation of the active principle of Helenine and its identification as a double stranded RNA led to the preparation of synthetic RNA compounds.[15, 16] One of the most promising of these compounds is the polyinosinic–polycytidilic acid complex (Poly I:C). However, because of its toxicity on parenteral administration there have been few studies on its efficacy in man.

Therapy of Mycoplasmal Infections

Mycoplasma organisms (also known as "pleuropneumonia-like" or PPLO) are not true viruses. They differ from viruses because they contain both RNA and DNA; they divide by binary fission; they grow on artificial media and are suceptible to certain antibiotics. Only three strains of mycoplasma have been definitely implicated as causative agents of disease in man. *Mycoplasma pneumoniae* is the etiologic agent of the "cold-agglutinin-positive" primary atypical pneumonia.[17] Complications are relatively infrequent, chief among those being tubular bronchiectasis which may develop in as many as 4.5% of patients.[18] The death rate has not been well delineated for PAP but is thought to be considerably less than 0.1%.

The second mycoplasma strain of clinical importance is the so-called "T-strain" of mycoplasma. These organisms may be responsible for some cases of nongonococcal urethritis. Finally, *Mycoplasma hominis* type-1 has been shown in volunteer studies to produce exudative pharyngitis, though the role of these organisms in naturally acquired nonstreptococcal pharyngitis cases remains to be proven.

Either the tetracyclines or the erythromycins are the drugs of choice for therapy of mycoplasma infections. The recommended doses of both erythromycin and tetracycline hydrochloride are between 1.0 and 2.0 gm per day, given orally in divided doses. We have recently treated, at the Milwaukee County General Hospital, 13 patients with the atypical pneumonia syndrome with the newest tetracycline, minocycline (Minocin®). The advantage of this antibiotic lies in its excellent absorption from the intestinal tract and a high degree of activity against many tetracycline-sensitive strains of bacteria. Minocycline is given orally, the initial dose of 200 mg is followed by 100 mg every 12 hours. Our patients have been treated for between five to seven days. The response in all of them was good and there were no complications referable to the therapy (G. J. Dorff and M. W. Rytel, unpublished data).

Therapy of Rickettsial Infections

Rickettsial infections are uncommon in the United States today, but they continue to account for a small and unnecessary number of deaths each year. Both the tetracyclines and chloramphenicol are effective in the treatment of the various rickettsial diseases, but early diagnosis is essential for optimum treatment.

Rocky Mountain Spotted Fever

At present, spotted fever—caused by *Rickettsia rickettsii*—is the most important rickettsial infection in the United States in terms of morbidity and mortality. Several hundred cases are reported each year and many more cases may occur. In the last several decades the disease has been most prevalent in the South Atlantic and South Central states. Infection is usually associated with the bite of an infected tick, but it may occur following the crushing of an infected tick against the skin. The illness is characterized by an abrupt onset of high fever, severe headache, and generalized myalgias. A migratory erythematous macular rash appears about the fourth day of illness on the wrists, ankles, soles, and palms. After two to three days the rash becomes generalized and maculopapular, then petechial, and eventually ecchymotic. Ecchymoses occur only at a very late stage of the disease.[19] Proteus agglutinin titers (Weil–

Felix reaction) are not reliable in the early stages of the disease. Although lymphocytes become sensitized to rickettsial antigen during the infection,[20] no skin test is presently available. Specific diagnosis can be established by measurement of complement fixing (CF) antibodies, but this test is useful only retrospectively. It is usually necessary to treat patients because of a high degree of suspicion based on the history and physical examination and by exclusion of other diagnoses.

Either the tetracyclines or chloramphenicol are effective in the treatment of Rocky Mountain spotted fever; however, chloramphenicol carries the added risk of marrow aplasia. Oral antibiotic therapy is effective in the early stages of the disease. For adults, chloramphenicol or tetracycline in a dose of 0.5 gm every four hours is adequate. Children may be given chloramphenicol, 75 mg/kg body weight per day or tetracycline, 25 mg/kg body weight per day in divided doses at six hourly intervals. Chloramphenicol is readily absorbed by the oral route, but care should be taken to administer tetracycline between meals to insure its absorption. Intravenous administration of antibiotics is mandatory when patients have reached an advanced stage of illness. In no instance should more than 2.0 gm of tetracycline or 3.0 to 4.0 gm of chloramphenicol be given daily. Administration of antibiotics intramuscularly is unwise because of the frequency with which thrombocytopenia and a bleeding tendency occur in patients with spotted fever. Furthermore, it is well established that chloramphenicol succinate is poorly absorbed after intramuscular administration, and its use cannot be recommended.[21]

There is no significant experience with the newer broad-spectrum antibiotics such as ampicillin or the cephalosporins in the treatment of spotted fever. Based on previous experience with penicillin G, these antibiotics are likely to be totally inactive. One of us (DC) is aware of a documented case of spotted fever which was treated with ampicillin for 10 days. The patient showed progressive deterioration on this therapy, but recovered rapidly during treatment with tetracycline.

Improvement is usually readily apparent within several days following specific antibiotic therapy. Antibiotics should be continued until the temperature has remained normal for two to three days. The need for supportive therapy varies dramatically with the duration and severity of the infection prior to specific antibiotic therapy. Severely affected patients suffer most frequently from circulatory collapse, coma and oliguria.

No treatment is required for contacts of infected patients or for well individuals who seek medical advice following a tick bite. Only a small fraction of ticks in a given locale are likely to harbor the rickettsiae of spotted fever, and it is unlikely that any given tick bite will be followed by infection. Since the clinical course of spotted fever is relatively prolonged and the response to antibiotics is rapid, it is sufficient to advise exposed individuals to report immediately to the physician if signs of illness appear. Members of the family of clinical cases should be warned to use gloves in removing ticks from household pets.

Vaccination has protective value against spotted fever. It may be worthwhile to vaccinate individuals at high risk such as campers or other individuals who frequent tick-infested wooded areas during the spring or early summer.

Q Fever

Q fever is caused by *Rickettsia burneti,* an organism unique among the ricketttsiae for its ability to survive for a long period outside a living host. Man is infected by inhalation of infected dusts or by ingestion of contaminated milk. The disease is characterized by fever, malaise, headache, and anorexia. Pneumonitis is present in from 0 to 100 percent of patients in different series depending upon the mode of acquisition of the infection. Chest x-ray findings are generally indistinguishable from atypical pneumonias due to other causes. Endocarditis has been reported with sufficient frequency to warrant consideration of the diagnosis of Q fever endocarditis in cases of suspected endocarditis with persistently negative blood cultures.[22] The diagnosis can be established by recovery of the organism from the blood by egg inoculation and by demonstration of the development of complement fixing antibodies.

Although either tetracyclines or chloramphenicol are useful in the treatment of Q fever, they are not as effective as in other rickettsial infections.[23] These antibiotics generally reduce fever, and otherwise result in symptomatic improvement. However, relapses occasionally occur and symptomatic improvement may be slow, especially if therapy has been delayed for several days after the onset of clinical illness. Fatalities are rare except in cases of endocarditis. Tetracyclines appear slightly more effective than chloramphenicol and are the antibiotics of choice.

Murine Typhus

Flea-borne (endemic, murine) typhus fever has become a rare disease in the United States in the past 20 years. Less than 50 cases are reported annually, and these are essentially limited to the southeastern states. The etiologic agent is *Rickettsia mooseri.* The illness is transmitted to man by rat fleas and is characterized by headache and fever, followed by a macular rash. The infection is relatively benign and the combined case-fatality rate for all age groups is about 2 percent. Tetracycline or chloramphenicol administration, as outlined above, for spotted fever is highly effective in experimental infections in animals and also appears effective in humans.

Rickettsialpox

Rickettsialpox is a mild and self-limited infection due to *Rickettsia akari*. It was first recognized in 1946 in New York City and subsequently in several other areas of the United States. Initially, several hundred cases annually were reported, but only a few cases have been reported in recent years.[24] The infection is transmitted to man from mice by mites. A distinctive primary lesion at the site of the mite bite occurs followed by a short febrile course with a generalized maculopapular exanthem. Deaths due to this infection have not been reported in the United States. Tetracycline therapy, as described above for spotted fever, reduces morbidity. Control measures are directed at elimination of house mice and mites.

Scrub Typhus

Scrub typhus is caused by *Rickettsia tsutsugamushi* and is limited to eastern and southeastern Asia, India, and northern Australia. It represents a potential medical problem in veterans returning from Asia.[25] The infection is transmitted incidentally to man by infected mites whose usual hosts are a variety of small rodents. Illness develops abruptly after an incubation period of 6 to 21 days with severe headache, fever, conjunctival injection, and lymphadenopathy. A primary lesion consisting of a 1 cm indurated area occurs at the site of the mite bite. A generalized red macular rash occurs about the fifth day of illness. Without treatment the mortality rate is high. The response to tetracycline or chloramphenicol (which should be given as outlined for the treatment of spotted fever) is dramatic. The penicillins and sulfonamides are of no value in uncomplicated scrub typhus. There is no satisfactory vaccine. Relapses may occur when short courses (two to three days) of antibiotic therapy are given.

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Vascular Component in Hemostasis

A. J. QUICK, MD, Milwaukee, Wis: *New Eng J Med* 283:186–189 (July 23) 1970

The two tests readily available to the clinical laboratory for evaluating the vascular phase of hemostasis are the bleeding time and the tourniquet test. For a reliable interpretation of the Duke bleeding time, two variables must be controlled: the temperature of the ear lobe and the drug intake, particularly aspirin, prior to the test. Cold prolongs the bleeding time in sensitive subjects. This also occurs after aspirin ingestion.

The tourniquet test requires a standardized constriction of the upper arm. The results of the test are gauged by the number of petechiae, their distribution, and their size.

In two cases of thrombopathy, one hereditary and the other acquired, no direct relationship between the thrombocytopenia, the Duke bleeding time, and the tourniquet test was demonstrable.

In two cases of telangiectasia, the tourniquet test was consistently positive and the aspirin tolerance test poor but variable in intensity. □

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OVID O. MEYER *Festschrift*

The Flower in the Lapel Will Be Missed!

OVID O. MEYER, MD TO BE EMERITUS

When Ovid O. Meyer, MD becomes an Emeritus Professor June 30, 1971, the Department of Medicine at the University of Wisconsin will observe the end of an era. Ovid Meyer was the second Chairman of this department, having succeeded Joseph Evans, MD in 1945, and he served until 1964.

Remembered by hundreds of medical students as a master bedside physician-teacher, Ovid Meyer is an internationally recognized expert on lymph node diseases, and he is one of the world's authorities in the use of anticoagulants. His early work on Dicumarol assured his niche in the hall of fame for clinical scholars. His studies of the interrelationship of the hormonal glands and the hemopoietic system are commonly cited references to this day. Concomitant with his scholarly research efforts he nurtured a broad interest in Internal Medicine. He is a keen diagnostician and has peerless clinical judgment—a fact which leads some interns to mistakenly think he is lucky or can "smell" a disease. With continued exposure to Ovid Meyer the house officers usually realize that "luck and sixth sense" are the products of assiduous reading and openness to new ideas and compassion for his patients. He has served as a model to be emulated by countless medical students and house officers.

During a time when house officer stipends were smaller than now, the medical residents counted as one of the high points of each year the invitation to dinner with Doctor and Mrs. Meyer. This usually occurred in February or March, a time of year in which a genuinely warm and friendly gesture was singularly appreciated. So many of us have fond memories of that delightful blend of Southern hospitality and Stevens Point French gemütlicheit.

During his period as Chairman, the department grew in size and quality. Programs in cardiovascular disease, hematology, pulmonary disease, endocrinology, psychophysiology, gastroenterology, laboratory medicine, computers, and nephrology were added or developed. As administrator of a large department his ability to adjudicate fairly was appreciated by all. The entire faculty of the medical school was confident that Ovid Meyer's efforts were consistently and effectively directed toward the improvement of our school. He firmly believed that the triad of teaching, research, and service was essential and therefore desirable in our medical school.

A number of Ovid's former residents and colleagues have indicated a desire to establish a fund in his honor to be used to improve clinical teaching in the medical school. The departmental faculty has to date pledged more than $10,000 to the fund. Because of his generous commitment to teaching students and interns as well, many others will wish to contribute to such a fund. Contributions can be sent to the Department of Medicine, University Hospitals, Madison 53706. The cause is nearly as worthy as the person whom we will honor and memorialize.

The editors of the Festschrift wish to thank those of you who have sent letters of tribute. Because of space limitations in the journal, we will present these to Doctor Meyer separately. We also wish to thank the contributors to this issue for their efforts in making this special issue possible.

As you might suspect, Doctor Meyer plans to be busy in retirement and will be an active teacher and consultant to the Veterans Administration with an office at the Madison Veterans Administration Hospital as part of the large and important Medical School program at that institution. We are pleased that he will continue actively in teaching.

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DOCTOR OVID O. MEYER
and the Department of Medicine
University of Wisconsin Medical School

By William S. Middleton, MD, Madison, Wisconsin

In a more placid period, a perceptive observer wrote, "An institution is the lengthened shadow of one man." (Emerson). In the more complicated and more intricately organized pattern of modern society, such circumstances have become increasingly more unusual. Particularly is this true in areas of rapidly expanding knowledge. As the picture of the Department of Medicine in the University of Wisconsin Medical School unfolds, it will become apparent that Ovid Meyer, although not a pioneer, has played the leading role in important phases of its present eminent position in the medical world.

OVID O. MEYER

Festschrift
WISCONSIN MEDICAL JOURNAL
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To set the background, clinical medicine at Wisconsin had its roots in 1910 with the establishment of the Student Health Service. Two superb clinicians, Joseph Spragg Evans and Robert Van Valzah, lent a quality of professional excellence to its inception that is appreciated even at this removed date. The Chief, Doctor Evans, was eminently qualified by domestic and foreign training in Philadelphia, Paris, and Vienna. A polished physician, his clinical skill was coupled with deep human interest. However, the exigencies of the local scene led to a transfer of his superior talents in a considerable measure from scientific pursuits at the bedside and in the laboratory to medical statesmanship in the interest of the struggling Medical School. He was nonetheless the architect of clinical development in this community. His first and most able assistant was Doctor Robert Van Valzah. The fourth in direct line, he embodied every attribute of the true physician. Highly intelligent, perceptive to a remarkable degree, his quiet, sympathetic approach brought peace to every sick room and comfort to every patient he attended. His patent sincerity established immediate rapport and earned the lasting confidence of everyone.

By the time Ovid Meyer was introduced to the Madison scene, the brilliance of Dean Charles R. Bardeen had planned and achieved the recognition of the two-year course (1907). By 1919 he had gained permission to establish a complete four-year curriculum in medicine at Madison. The conversion of Governor Emanuel Philipp with a release of excess sums from the Service Recognition Fund for the construction of a memorial in the form of the State of Wisconsin General Hospital was Doctor Evans' responsibility (1920). In spite of certain delays, the construction of the Hospital was completed (1924) just after Ovid Meyer completed his baccalaureate requirements in the College of Letters and Science. Somewhat earlier (1919–20) funds from private sources, supplemented by lesser monies from the State, had initiated permanent clinical facilities in the Student Infirmary and the Mary Cornelia Bradley Memorial Hospital. These areas were to be the scene of Ovid Meyer's clinical maturation and ultimate decisive role in the evolution of the Department of Medicine.

The son of Otto F. and Elmere E. (Belanger) Meyer, Ovid was born in Stevens Point on Dec. 17, 1900. A portion of his childhood was spent in Rosholt. In the eighth grade he won his first prize with an essay on "The Harm of a Single Glass of Beer"! The family returned to Stevens Point (the "Athens of the Middle West", to hear him talk), from where he entered the University of Wisconsin. His preclinical course was interrupted in the senior year (1923–4) by a sequence of serious illnesses that confined him to the University Infirmary. These enforced absences left him with a deficiency in physical diagnosis that was required for admission to advanced standing at Columbia. Accordingly arrangements were made for him to take this course in Summer Session (1924). The instructor with a class of only three (3) students essayed an experimental approach to his personal satisfaction, at least. An incidental by-product of this intimate association with Ovid Meyer as a patient and as a special student was the appreciation of his independent thinking and his lucid judgment.

Upon the completion of his admission requirements, Ovid was accepted by the College of Physicians and Surgeons, Columbia University. The degree of Doctor of Medicine was granted in 1926. Ties earlier established drew him back to the Wisconsin General Hospital for his internship (1926–7). Here his superior performance, coupled with his personal attributes of diligence, fidelity to high ideals, and intellectual integrity, made him the

From the Veterans Administration Hospital, Madison.
Reprint requests to: William S. Middleton, MD, 2114 Adams St., Madison, Wis. 53711.

logical successor to Edwin D. McKinley as Chief Resident in Medicine. In this position of dignity and responsibility (1927–9), he advanced steadily in professional stature and in the respect of his associates, both contemporary and senior. His inquisitive mind found companionship with fellow resident (EENT) L. H. Quinn in the study of "The Relationship of Sinusitis and Bronchiectasis." These workers demonstrated the insufflation of intranasally introduced iodized oil (Lipiodol®) into the tracheobronchial tree when the cough reflex was obtunded by sleep or sedative medication. Ovid Meyer's active participation in the studies of venous pressure (with W.S.M.) eventuated in two papers. One of these, "The Influence of Respiration on Venous Pressure," was the first presentation before the newly organized Central Society for Clinical Research (1929).

To broaden his prospect in research, on the completion of his residency at the Wisconsin General Hospital, Ovid went to the Collis P. Huntington Memorial Hospital, Boston, to work with Joseph C. Aub. Here studies in cancer, tissue metabolism, and hematology (1929–32) afforded him a clear insight into certain aspects of methodology and lent a new dimension to his clinical as well as his research approach that he has never lost. At this time he held an Assistantship in Medicine at Harvard. In 1932 he transferred as Assistant Physician to the Thorndike Memorial Laboratory to associate with George R. Minot—a coveted opportunity.

On Aug. 23, 1932, however, the sudden death of Ray C. Blankinship left a serious gap in the staff at Wisconsin. Doctor Evans called me into his office and said, "Bill, you must have given some thought to Blank's successor. Would you choose another gastroenterologist? Or should we select a man with a broader prospect?" After an interchange, I expressed the opinion that at that period we could not encourage too limited specialization. The Chief agreed and Ovid Meyer was his choice. It befell my lot to approach Doctor Minot for Ovid's release. When the situation was explained to him, he was most gracious and agreed to let us have him, if he wished to return to Wisconsin. Incidentally Doctor Minot inquired, "By the way, Middleton, what rank will you offer Meyer?" When I indicated the Assistant Professorship of Medicine, he said, "Fine. That's fair."

So Ovid Meyer returned to the Department of Medicine at Wisconsin (1932), where he was to exert such a profound influence upon its subsequent development. He early sensed the unique opportunity in clinical hematology. Charles Henry Bunting had had a lifelong devotion to cytologic studies of the blood and blood-forming organs. In this fallow field Ovid saw an unexploited opportunity for clinical advancement. Fortuitously Ethel M. Thewlis' services were available and her recruitment was arranged. A graduate nurse, she had developed a superlative knowledge of the cytology of the blood by an unusually comprehensive approach. Painstaking instruction in histology from William Snow Miller and in pathology from Doctor Bunting laid the substantial foundation. Thereafter came her engagement in the office of Doctors Minot and William B. Murphy in Boston for about two years. Room 507, Service Memorial Institutes, was assigned to clinical hematology by the Department of Pathology—a very felicitous arrangement. It immediately became a beehive of productive activity and Ovid Meyer was the catalyst. His basic observations on the relationship of the hypophysis to hematopoiesis (with Creep, Stewart, Rusch, and Thewlis) gained wide attention at this period (1935–37–40).

Dr. Ovid O. Meyer during internship: 1926–7.

One of the most conspicuous and farthest reaching of Ovid Meyer's contributions to the growth of the Department of Medicine was his role in the organization of the Institute for the Consideration of the Blood and Blood-Forming Organs (Sept. 4–6, 1939). With the financial support of the Wisconsin Alumni Research Foundation, a remarkable group of active workers in this field accepted places on the program, and a large and appreciative audience justified the effort. The participants were Louis K. Diamond, Charles A. Doan, Hal Downey, Harry Engle, Claude E. Forkner, J. Furth, Russell Haden, Clark W. Heath, E. B. Krumbhaar, E. Meulengracht, George R. Minot, Edwin E. Osgood, Paul Reznikoff, C. P.

Rhoads, and Cecil J. Watson—truly a Blue Ribbon registry of research hematologists of that day. Doctor Minot was quite the lion of the hour, for as Ovid Meyer stated in his foreword to the published Symposium, "The golden era of hematologic research began with the establishment of the value of liver therapy in pernicious anemia." In his address of welcome, President Emeritus Edward A. Birge, eminent limnologist, struck a happy note when he remarked, ". . . where the joke lies this morning, when a devotee of water welcomes to this campus on the shores of Lake Mendota you who are members of the first American symposium on the blood." By rare good fortune Professor Meulengracht had been able to effect the passage from Copenhagen after World War II was declared. As the after-dinner speaker, in a country recently released from prohibition, he took his audience by storm when he said, "Now I must ask you to remember that I come from a country where, since the days of the Vikings some thousand years ago, we have never had a single day of prohibition, and where

A SYMPOSIUM ON THE BLOOD AND BLOOD-FORMING ORGANS

Addresses given at an Institute Conducted by the Medical School of the University of Wisconsin

September 4-6, 1939

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Two clinical investigators explore venous pressure determination: Ovid O. Meyer, observer, and William S. Middleton, observed

it has always been considered proper to work—or fight—by day and to drink at dinner as did the Vikings."* And Ovid Meyer agreed!

The timing of the Institute was opportune. The selection and the performance of the participants were eminently superior. The organization and conduct of the program left nothing to be desired. Its success was acclaimed throughout the medical world. The resultant "A Symposium on the Blood" was published under the aegis of the Wisconsin Alumni Research Foundation and was warmly received by the profession. Unquestionably, this Institute under the able chairmanship of Ovid Meyer greatly enhanced the reputation of the University of Wisconsin and its Medical School. For years to come the Institute was to be cited as the model for similar enterprises.

Meanwhile Ovid Meyer's energies had been extended in other directions. A glance at his bibliography affords some insight into his basic interests. His studies of disorders of the blood-forming organs covered a wide range of subjects. Not infrequently the influence of the Boston interlude impinged on a basic principle involved in a clinical problem. Patient oriented, his clinical studies commonly had a therapeutic objective. So it came to pass with Karl Paul Link's discovery of the anticoagulant property of 3,3′-methylenebis [4-hydroxycoumarin] in spoiled sweet clover, Ovid Meyer spearheaded the clinical studies on this potent agent at Wisconsin. In all, with collaborators, he published 16 papers on the subject. His authoritative position has been recognized nationally and internationally. His historical account of coumarin (*Circulation* **19**:114 [Jan] 1959) is a faithful account of the Wisconsin experience. In this sustained effort as in all other studies, where it has been possible to include associates as joint authors, with his innate sense of fairness, he has done so. Naturally as his right bower, Ethel Thewlis appears as a frequent co-writer; but more significant is the arresting inclusion of many residents in this felicitous relation. Turning to their chronologic order, Stewart, Krueger, Allin, Bingham, Thill, Sikkenna, Richtsmeier, McCoy, Abrams, Battle, Rotter, Magnin, Korst, Clatanoff, Freeman, and Ward appear as his co-authors in their several cooperative studies. His adherence to this thoughtful practice redounds to his credit and to the great advantage of the oncoming generation of house officers.

The knowledge garnered from a wide clinical experience is demonstrated by Ovid Meyer's lucid discussion of drugs and blood dyscrasias (1965). The wisdom of the true physician emerges in his perceptive discussion of certain symptoms and signs of anxiety states (1952–54). Only to such an acute observer would sighing respiration, tinted eye glasses, sweaty axillae, and bitten finger nails have a common basic significance. Always a careful student of diseases of the lymph nodes, he gave especial attention to their treatment with newer potent agents. He made one of the early reports on the anticipated changes in follicular lymphoblastoma (1948).

War clouds were lowering. The 135th Medical Regiment with many medical officers from the Medical Faculty was activated with the 32d Division in 1941. The 44th General Hospital recruited largely from the medical and nursing personnel of the University Hospitals as an affiliated unit, was inducted to serve in separate hospitals in continental United States before its assignment as a whole to active duty in the South West Pacific Theater in 1943. Others answered the call in different capacities. With the withdrawal of many senior as well as junior staff members for military service, the depleted faculty drew its collective belt tighter and under the leadership of Acting Dean Walter J. Meek rendered Herculean effort. Viewed in retrospect, the contribution of this holding Faculty to the ongoing demands of the existing situation and to the continuity of its projected functions cannot be overestimated. In the absence of other senior members of the Department of Medicine and with Doctor Evans' gradual relinquishment of supervisory duties, Ovid Meyer took increasing responsibility in the administration of the Department. Nevertheless during World War II (1942–45) with overwhelming teaching, clinical and administrative duties, he published twelve (12) creditable papers—a prodigious output.

Academic recognition came regularly to Ovid Meyer. From his original appointment as Assistant Professor of Medicine (1932–37), he was advanced to Associate Professor of Medicine and Associate Physician to the University Hospitals in 1937 and to Professor of Medicine and Physician to the University Hospitals in 1944. Upon my return from service (1945), the question of the succession to Doctor Evans in the Chairmanship of the Department of Medicine arose. When I reluctantly assumed

* Although the prohibition era ended in 1933, no alcoholic beverages were served on this evening.

the Deanship of the Medical School (1935), I had exacted a pledge from the Chief that he would support me as his successor upon his retirement. Sorely troubled, he said, "Bill, I know that I have commited myself to you in writing on this score; but the war has made a great deal of difference. You have been away for the duration. Ovid Meyer has carried the burden of the Department for almost four years. He is thoroughly acquainted with the details of its operation. He has the confidence of the staff and the administration. Frankly without his effort and that of Harold (Coon), I do not think we could have survived. I think he should be made Chairman of the Department." Having reflected on this matter frequently when removed from the scene and then with the opportunity to observe Ovid Meyer's remarkable accomplishment at first hand, I agreed with Doctor Evans without reservation. I have never regretted my decision.

Of course, at times I have seriously questioned Ovid's judgment on sporting events. His luck went out with Babe Ruth. Professional judgment is another matter. He's tops. His physical constitution is not too sturdy. One episode (1935) is recalled most vividly. Classical angina, with electrocardiographic changes suggestive of myocardial infarction, disappeared promptly with rest alone, to reappear on smoking a single cigarette. Withdrawal of the weed spared him to us. (Ovid now plays with little cigars. Or is it purall cubebs?) Then, too, not being the physical type, he surprised all of us by sustaining a tibial fracture (1949). An official note in the Hospital record bears eloquent proof of unusual care from an eminent authority, as follows:

"April 7, 1949

"To whom it may concern,

"This will be construed as official announcement that the medium, semi-long, modified short cast applied this day to Dr. O. O. Meyer is strong, light, smooth, hard, white, unpadded, sturdy enough to withstand the rigors of convalescence at home but beautiful enough for the ballroom or the conclaves of the mighty, a thing of enchanted beauty, in fine, a superb example of the ideal of every bonesetter.

"I put it on.

H. Wirka"

Under Ovid Meyer's Chairmanship, the Department of Medicine showed a sustained growth in numbers and strength. From my vantage point as Dean, it was gratifying to observe his quiet but firm leadership. Excellent interpersonal relationships were maintained within the Department and among the other elements of the Medical School and the University at large. Even when strict, and at times adverse, rulings were imposed by him, his eminent fairness was admitted by all. Perhaps the most serious loss to the Department in the early period of his tenure was the untimely death of Frederick J. Pohle (1947), whose fine analytic mind gave great promise of a brilliant future. By all, he was considered Ovid's most able lieutenant. In general recruitment to his staff Ovid Meyer exercised mature judgment with a broad view to the future requirements of the Department and the Medical School.

Participants in the Invitational Radioisotope Conference—A Symposium on the Use of Isotopes in Biology and Medicine—*held the week of Sept. 10, 1947, at the University of Wisconsin Medical School. This was the first conference ever to be held on the use of radioisotopes in medicine. Symposium published by University of Wisconsin Press, Madison, 1949. Above, back row: Norris F. Hall, Edward B. Hart, and C. A. Elvehjem; front row: William S. Middleton, Farrington Daniels, and Ovid O. Meyer.*

Arriving at his administrative responsibilities in a period of transition, Ovid capitalized on his background of clinical and scientific training to insure an appropriate development of the latter without sacrifice of the former in the primary mission of producing thoughtful practitioners of medicine. Never was bedside instruction neglected in his pattern of operation. On the foundation of the Evans–Van Valzah tradition, he built a superstructure of more sophisticated specialty education by the gradual introduction of increasing numbers of subspecialties with their respective representatives. On the Wisconsin scene, the study of cardiovascular diseases had a natural setting in the fundamental contributions of English Eyster and Walter J. Meek to the physiology of the circulation. In fact, they were among the first students of conduction faults in the myocardium in this country. The former's studies on heart size gave impetus to Chester M. Kurtz's observations on orthodiascopy. Certainly their influence on Kurtz and Herman H. Shapiro was unmistakable. Singularly, William Snow Miller never found a physiologic helpmeet for his superb study of the lung. However, before Ovid Meyer's tenure as Chairman, Reuben H. Stiehm, William H. Oatway and Helen A. Dickie, with the cooperation of the Department of Surgery, had consolidated a strong beachhead in pulmonary diseases in our midst. The early efforts of Ray C. Blankinship and Karver L. Puestow had afforded gastroenterology a fair beginning. William A. Mowry gave allergy a small start. Elmer Sevringhaus and Edgar S. Gordon had laid a strong foundation in endocrinology and metabolic diseases in our midst. Psychosomatic medicine was afforded splendid leadership by Marc J. Musser (1946) and Thomas Lorenz (1951). Ovid Meyer, himself, instigated the subdivision of hematology; but if we take his own

A group of the House Staff of Wisconsin General Hospital. Front row: Meyer, Lichty, Sennhauser, Outhouse, Giryotas, Taylor, and Gibson. Back row: Bigler, Stiehm, Beyer, Cassidy, Masten, Coon, McKinley, Warner, and Fogs.

activities as the early pattern, he never permitted his clinical outlook to be sharply delimited by his research interest. However, pursuing this approach in its ultimate evolution, Ovid Meyer shortly recruited Fred Pohle (1938) and after World War II Robert F. Schilling (1951). Dallas Clatanoff was a product of Meyer's own making, unfortunately lost to the Department by his early tragic death. Quite obviously Ovid was setting a pattern of scientifically oriented members in his immediate associates with hematology as their focal point. In each instance the carefully chosen men had a broad clinical prospect as a backdrop for their subspecialty. After this plan each subspecialty was evolved and staffing in varying depths has been arranged.

Under the organizational pattern of the Medical School, the Department of Medicine when Ovid Meyer assumed its Chairmanship (1945), included ten subsections, namely Allergy, Cardiology, Chest (7th floor), Dermatology, Endocrine and Metabolic Laboratories, Outpatient Department, Pediatrics, Physical Medicine, and Student Health. Divested of all staff members not directly responsible for the care of adult patients, the 1945 Faculty upon the return of officers from the military service numbered 7 professors, 4 associate professors, and 6 assistant professors—a total of 17 in professorial grades.

With the burgeoning requirements of the post World War II period, there came an interesting utilization of the staff and clinical facilities of the hospitals of the community in the educational programs of the Medical School. Under the far-seeing design of the Dean's Committee affiliated with the Veterans Administration Hospital (1951), this arrangement was especially fruitful. Then, too, by 1965 the subsections of the Department had expanded from 10 to 17 by the addition of Cardiology Research, Gastroenterology, Occupational Therapy, Psychosomatic, Pulmonary Function Laboratory, Renal (with dialysis), and Veterans Hospital.

In this period of phenomenal expansion, the faculty, using the same criterion of direct clinical responsibility for adult medical patients as in 1945, in 1965 showed 9 professors, 3 clinical professors (1 VA), 4 associate professors, 12 associate clinical professors (3 VA; 9 part time), 7 assistant professors, 11 assistant clinical professors (4 VA; 7 part time)—a total of 46.

The budget of slightly less than $80,000 for the year 1943–44 for all demands of the Department saw an increase to over $1,000,000 in 1963–64. Significant in the latter figure was over $500,000 from Federal sources for research (salaries and incidentals thereto pertaining). Most astounding in this direction has been Ovid Meyer's personal success in enlisting the financial backing of individuals as well as foundations for staff, research projects, and special equipment; viz., the artificial kidney. His own efforts have brought approximately $1,000,000 to the Department of Medicine during his Chairmanship.

Significant as part and parcel of the general growth were the additional spaces afforded Cardiovascular Research by the addition of the fifth and sixth floors to the McArdle Laboratories (1952) and the area assigned to Medicine in the Medical Science Building (1960). Hematology gained breathing space thereby. Readjustment and remodeling of the exist-

ing crowded space in the University Hospitals accommodated the pulmonary function laboratory, the new dialysis program, and the Intensive Care Unit.

With this stupendous growth have come increasing numbers of research fellows and staff members. Enviable recognition has accrued to their efforts from national and international sources. Coveted awards have been gained by members of the Department; i.e., Markle Scholarships, George G. Rowe and John Rankin; National Institutes of Health Career Awards, Jack Chosy and George G. Rowe; and a Research Career Professorship, Robert F. Schilling.

Ovid Meyer brought the program of Visiting Professorship in Medicine to Wisconsin (1959). To the termination of his tenure, its occupants have been:

1959—Joseph C. Aub	1962—J. Snapper
1960—Carl Moore	1963—Dickinson Richards
1961—Maxwell Finland	1964—Jan Waldenstrom

The success of this effort is one of Ovid's proudest achievements.

The Meyer family ties have always been very close. The father was a solid, prosperous pharmacist. The mother was a warm, lovable, vivacious soul, whose maternal pride left an indelible mark on her son. Furthermore, Ovid Meyer owes a great measure of his religious devotion to her wonderful example. On June 24, 1932, Ovid married Lyda Ann Henry of Alabama in Boston. A splendid, high-spirited helpmate, Lyda Ann shared his trials and triumphs. Theirs was a life of complete mutual understanding. Three children, Nancy A., Mary Lynn, and Ralph H., were born to them. Ovid was desolated by Lyda Ann's sudden death from a cerebral vascular accident, Aug. 4, 1968. Some solace is derived from his immediate family with the ten grandchildren. In Ralph's position as Assistant Superintendent of the new Hershey Medical Center Hospital with many innovative details of design and operation, Ovid takes justifiable interest and pride.

The Chief's office

Ovid Meyer is a man of many parts and achievements. Hence one must look deeply to establish the least common denominators of his character. Primarily he is humanitarian in his basic motivation. He likes people and is innately gregarious. He is intensely loyal. His ready smile and firm handclasp reflect his warm personality. The constant boutonniere, usually pilfered from a patient's plant or bouquet, is his hallmark of cheer and comfort to the sick and afflicted. Regardless of his personal cross, he never takes his cares into the sick room. Incisive in his judgment, he is not easily swayed. A measure of dogmatism is an asset in his teaching. One element of strength in his public address is his lucid organization of his subject matter. He has a tidy mind and leaves no loose ends. From a personal viewpoint, I can testify that neither time nor circumstance interferes with his devoted, skillful attention in the hour of need. "The art of medicine consists of a sound scientific foundation with a superstructure of carefully evolved compartments, in each of which the physician stores his observations, trials and errors against similar situations that may arise in the future." (W.S.M.) Few physicians of our period have more completely fulfilled these criteria for growth. So while Ovid Meyer has contributed mightily to the transition of our Department of Medicine from a sound conventional element of this great Medical School to its present balanced sophisticated status with strong subspecialty representation, to me his stature is even greater as the consummate bedside clinician. To him comes the accolade of a host of patients, students, fellow practitioners, and friends, a true physician's physician with all the affection and esteem the term embraces. □

One of the Chief's annual birthday parties given by the Nursing Staff of University Hospitals (1962). With Doctor Meyer are Miss Esch, Mrs. Aikens, and Miss Denny.

Carcinoma of the Thyroid Following Ionizing Radiation for Hodgkin's Disease

By Ovid O. Meyer, MD, Madison, Wisconsin

OVID O. MEYER

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WISCONSIN MEDICAL JOURNAL
MAY 1971

It has been recognized, at least since 1950, that ionizing radiation directed to the neck and upper mediastinum might be followed, years later, by carcinoma of the thyroid. This has been observed mainly in children and young adults who have received roentgen irradiation for benign lesions such as an enlarged thymus, hyperplasia of the tonsils and adenoids, tuberculous adenitis, cellulitis and furunculosis of the face and neck, acne vulgaris, thyrotoxicosis, and other less common lesions. The thyroid neoplasm has usually been a papillary carcinoma (54 percent in Duffy and Fitzgerald's series of 28 cases[1]) and recognized most often before the age of 18. Doses from 130 r to 2,700 r were administered and the latent period usually was from 5 to 18 years.

Recent assessment and survey of the risk of thyroid neoplasm after irradiation has been made by Hempelman[2] and by Pifer, et al.[3] There is one case cited of treatment for Hodgkin's disease of the neck nodes being followed by carcinoma of the thyroid[4] and another diagnosed as Hodgkin's disease, treated at various node sites commencing at the age of 8.

This article was prepared and submitted to the *Wisconsin Medical Journal* by Doctor Meyer without his knowledge of a Festschrift issue being developed in his honor. The Editors felt this special issue particularly appropriate for its publication. Doctor Meyer has also written an editorial entitled, "Hodgkin's Disease in the New Decade," which appears in this issue at page 23.

Thirteen years after the initial irradiation to the neck, a nodular thyroid mass was observed and seven years after that, in January 1963, thyroidectomy was done. This showed a follicular carcinoma with capsular, lymphatic, and venous invasion. Review of the lymph node biopsy of 1943 was interpreted as only hyperplastic lymphadenitis, not malignant lymphoma.[5] The fact that roentgen therapy to malignant lymph nodes is rarely followed by the development of thyroid carcinoma is readily explained, I suppose, by the usual short life expectancy of these patients.

The case here described is unusual, but in view of the current practice of extensive radiation perhaps one may anticipate more frequently development of carcinoma of the thyroid.

Case Report. A seven-year-old boy, was first seen on June 7, 1937. He complained of tiredness and enlarged lymph nodes that had been noted since scarlet fever. At the time of admission, the patient appeared to be moderately ill. During his hospital course, he commonly had a temperature to 100 F. There were firm, discrete, nontender, enlarged anterior cervical lymph nodes on the right, and varying in size from a "pea to a large walnut." There was dullness in the second and third left interspace of the anterior chest and some decrease in breath sounds. The spleen was palpable to the level of the umbilicus and to the midline. The liver was just palpable. There was no

Fig. 1—Chest x-ray film taken June 7, 1937.

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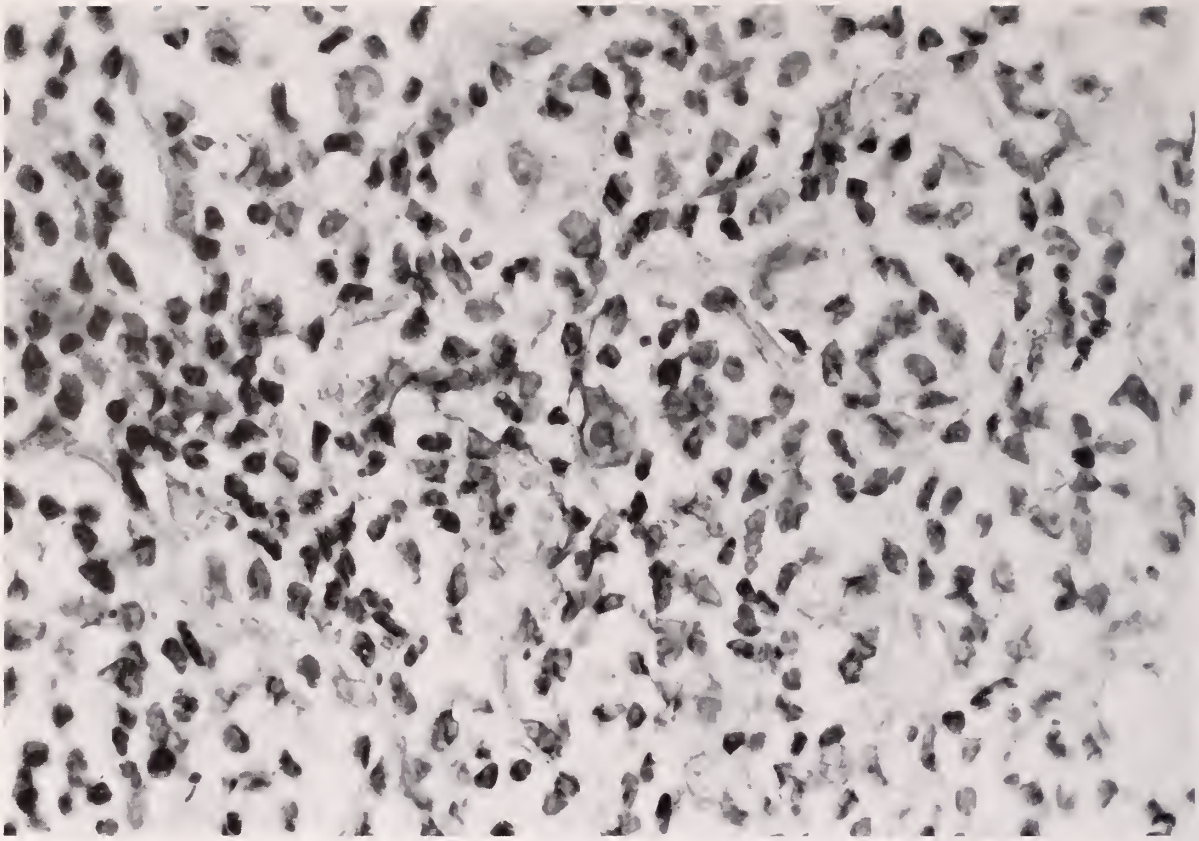

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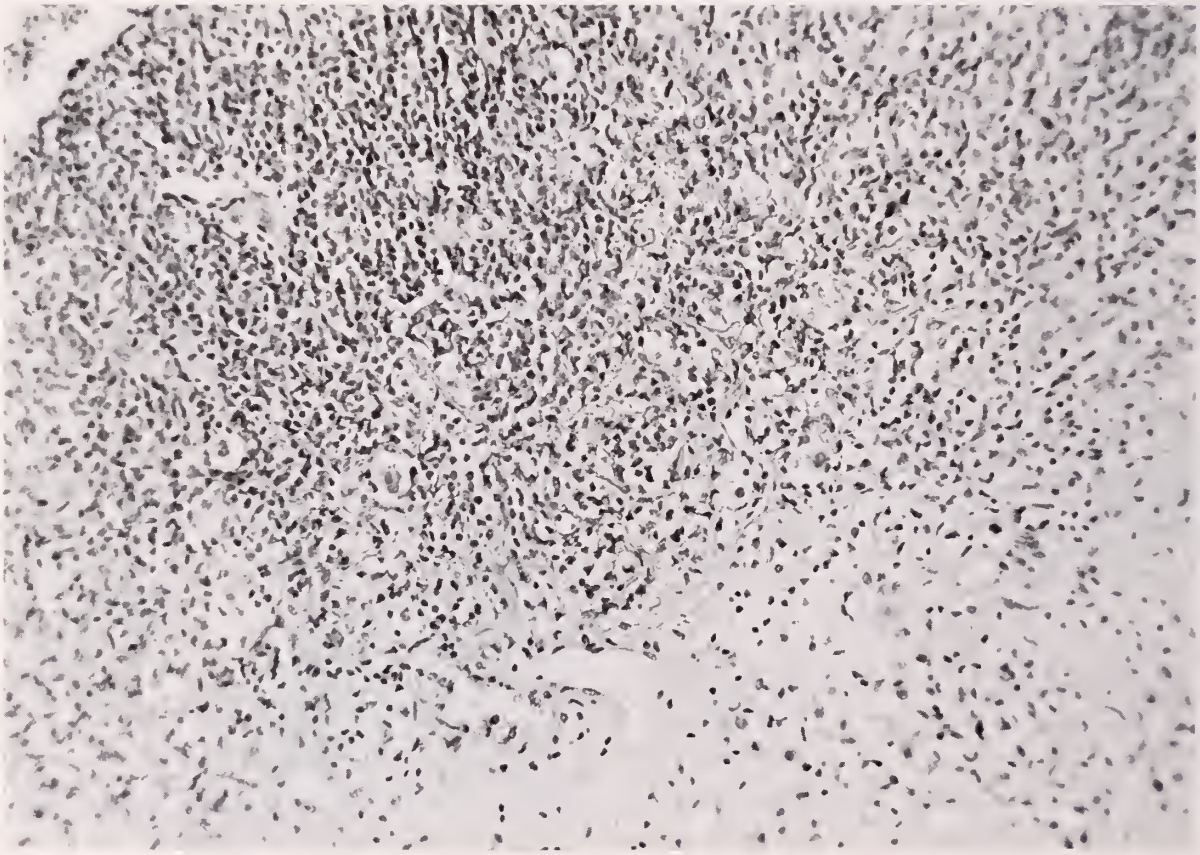

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Fig. 2—Microscopic section of cervical lymph node, 1937.

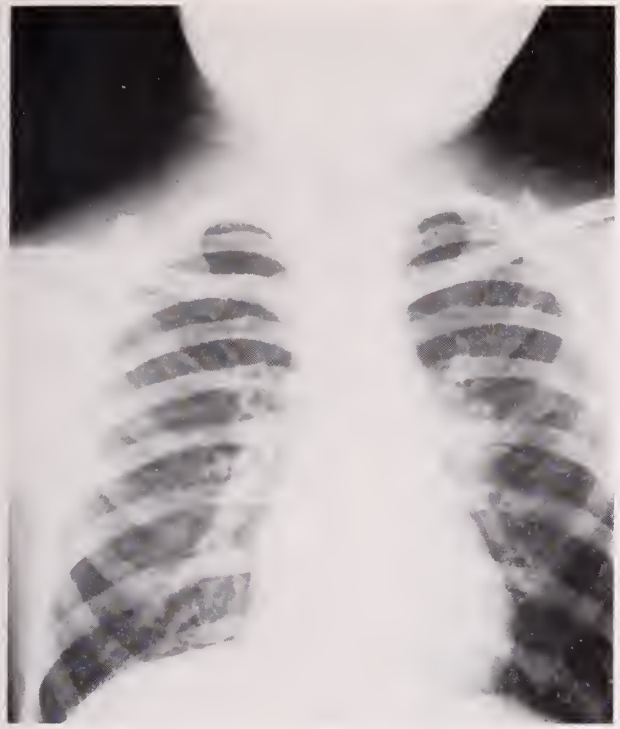


Fig. 3—Chest x-ray film taken Oct. 4, 1937.

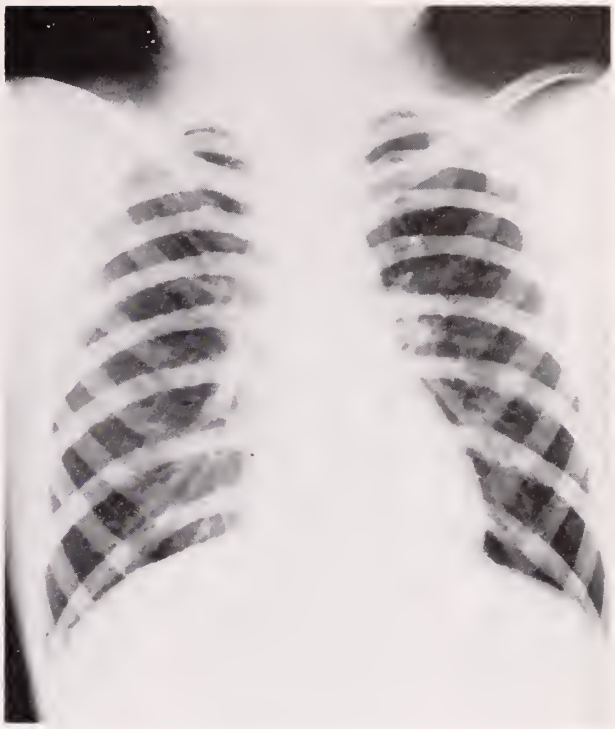


Fig. 4—Chest x-ray film taken July 17, 1939.

demonstrable enlargement of the axillary or inguinal nodes. Hemoglobin level was 71%; red blood cell count (RBC), 3,900,000; white blood cell count (WBC), 7,800 per cu mm with 59% neutrophils, 14% mononuclears, 15% lymphocytes, and there was a moderate increase in the platelets in the smear. Serology was negative. X-ray and fluoroscopic examinations showed a mass made up of several nodules, apparently arising within the mediastinum and extending into the lung fields on the left (Fig 1). Biopsy of a cervical node was reported as Hodgkin's disease (Fig 2).

From June 10 to June 18, 1937, radiation therapy was directed to the anterior and posterior mediastinum, anterior and posterior spleen, and the right cervical area. The therapy and technical factors between June 1937 and July 1939 are shown in Table 1.*

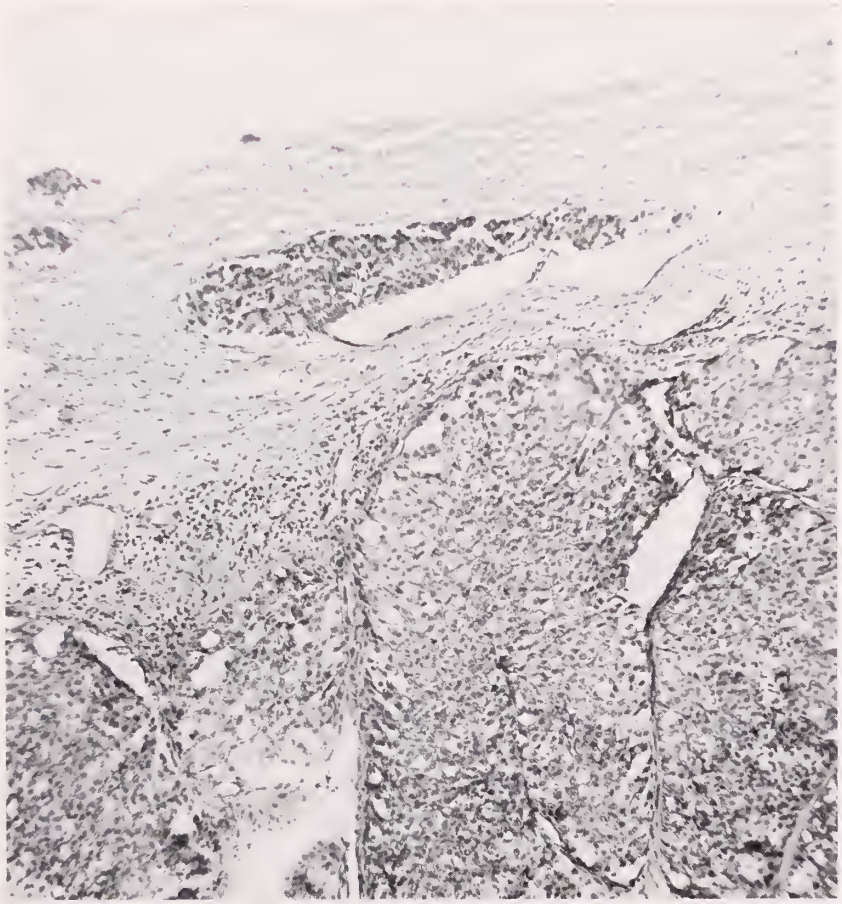
October 1937, the mediastinal mass had become smaller (Fig 3). The spleen was distinctly smaller but cervical nodes were still palpable and there were palpable inguinal and axillary nodes. When seen in March 1938 he was much improved and had gained weight. There was a small right and left epitrochlear node palpable. The spleen was not palpable. Hemoglobin level was 60%; RBC, 4,000,000; WBC, 4,600 per cu mm with 83% neutrophils. He was seen at irregular intervals. His last therapy for Hodgkin's disease was in July 1939 at the age of 9. Chest x-ray film at this time is shown in Figure 4.

In November 1967, at the age of 37, he noted a new node in the right supraclavicular region. His physician did a biopsy and the diagnosis was adenocarcinoma with follicle formation, thought to be metastatic from the thyroid. The patient denied any pulmonary or gastrointestinal symptoms. There were no other palpable superficial nodes and the spleen was not felt. Laryngoscopic examination was normal. Chest x-ray film was reported as normal. I^{131} uptake by the thyroid was 18% and a scan revealed the thyroid gland to be top normal in size. There was a probable cool nodule in the lower pole of the left lobe and also an area of decreased activity along the medial aspect of the upper pole of the right lobe. Gastrointestinal roentgengraphic studies and intravenous pyelograms showed no primary lesion. A nephrotomogram and later a renal arteriogram established no lesion in the kidney, although there was suspicion that there was an extrinsic pressure on the left pelvis. There was a radiolucent area with rather indistinct edges and a possibility that this represented a renal mass. Hematocrit reading was 47%; hemoglobin level, 16 gm/100 ml; erythrocytes 4,900,000; platelets, normal in the smear; leukocyte count 6,700 with 74% segs; BUN, uric acid, cholesterol, calcium, phosphorus, bilirubin, SGOT, alkaline phosphatase, and total proteins were all normal.

TABLE 1—*Dosage and Sites of Roentgen Therapy*

Date of Treatment		
1937: June 10–18	Mediastinum @ 8 cm depth 175 KVP, 1.35 mm Cu HVL	1630 rads central axis mid-line
June 14–16	Spleen @ 7 cm depth 175 KVP, 1.35 mm Cu HVL	810 rads central axis mid-line
June 16–18	Right Cervical @ 4 cm depth 175 KVP, 1.35 mm Cu HVL	440 rads
1938: March 21–26	Right and Left Cervical Inguinal @ 4 cm depth 160 KVP, 1.05 mm Cu HVL	415 rads
1939: May 8–11	Mediastinum 175 KVP, 1.35 mm Cu HVL	1275 rads central axis
July 17–20	Right and Left Cervical Inguinal Axilla @ 4 cm depth 160 KVP, 1.05 mm Cu HVL	550 rads central axis

* June 1941, patient received roentgen therapy for three verrucae on the right hand 750–750 and 1250 rads respectively. June 1943, patient received roentgen therapy to a 2-cm flat mass beneath the nipple of the right breast for mastitis, 445 rads.



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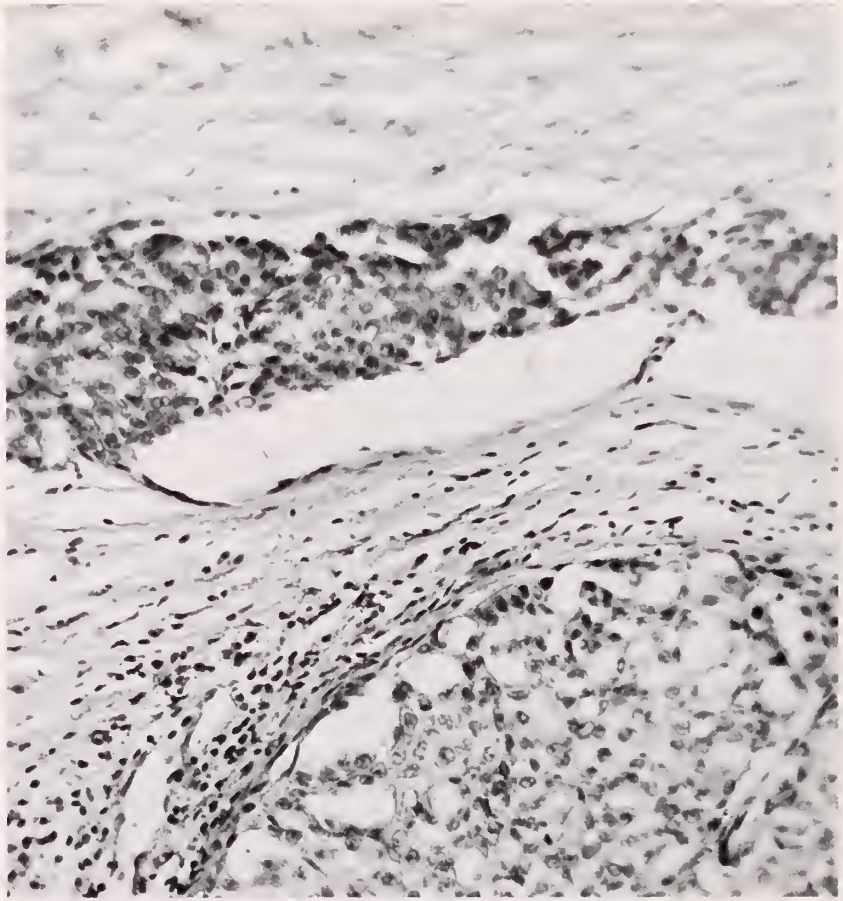

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Fig. 5—Section from thyroid, December 1967; changes akin to those of supraclavicular node biopsy of November 1967 follicular carcinoma.

On Dec. 20, 1967, Dr. J. R. Pellett did a total thyroidectomy with right radical neck dissection, left jugular node dissection and superior mediastinal node dissection. A multinodular thyroid was found containing foci of follicular carcinoma. There was involvement of nodes lateral to the jugular trunk on the left and involving the innominate vein and trachea in the substernal space. A node just superior to the pericardium lying on the trachea and partially adherent to the innominate vein was found to be positive on frozen section. Representative sections were made from the thyroid and all the lymph nodes. The mediastinal node was positive for tumor. The jugular, inferior thyroid, and recurrent nerve lymph nodes were all positive. Retrotracheal nodes were also positive. The right thyroid lobe was fibrocalcific and free of carcinoma, the left was positive for tumor and the interpretation of the thyroid and node pathology by Dr. Walter Jaeschke was follicular adenocarcinoma. Figure 5 shows microscopic sections of the thyroid.

On Jan. 29, 1968, thyroid scan using 100 microcuries of I^{131} revealed a small nodule of functioning tissue to the right of the midline in the bed of the thyroid gland. This was thought to be either residual tissue or possibly a tumor nodule. There was also a nodule of functioning tissue in the mediastinum. It was thought then that he had residual functioning thyroid cancer in the mediastinum and he was given 100 mc of I^{131}. On Feb. 2, 1968, eighteen hours later it was noted that there was good concentration in the mediastinum at the level of the aortic arch indicating satisfactory distribution. The patient developed some cardiac symptoms at home, but from the standpoint of his neoplasm he has been well. The patient had been admitted to the hospital on May 3, 1970, with a large left pleural effusion containing malignant cells. He was last seen on Oct. 9, 1970, at which time new superficial lymph nodes had appeared.

Discussion. We are dealing with a man who 31 years ago had Hodgkin's disease and was treated with what we now consider to be moderately small increments of irradiation although several areas were treated. Had we been staging the tumor at that time, we would have put this in class III-B or possibly IV. It is a fair assumption that, although a secondary primary malignancy is not positively excluded, the radiation had something to do with the development of the carcinoma. Admittedly few people with Hodgkin's disease live as long as has this young man; i.e., long enough to develop carcinoma. However, with the increasing incidence of so-called cures and with the employment of doses of 3,500 to 4,000 rads, one wonders whether we will see a higher incidence of carcinoma 10, 15, or 20 years hence. I think that we must be alert to this possibility.

Saenger, et al[6] after their survey of neoplasia following irradiation for benign conditions and finding a high incidence as compared to sibling controls, concluded that radiation did not appear to be the sole factor for the increased incidence of tumors but rather a contributing factor.

The studies of Doniach[7] in rats suggest a possible method of preventing thyroid carcinoma after irradiation to proximal sites. She showed that rats injected with 30 mc I^{131} and kept on methylthiouracil for the succeeding 15 months showed adenomatous replacement in the thyroid gland and occasional thyroid carcinomas. Unirradiated controls given methylthiouracil for 15 months developed some adenomas but no carcinomas. Based on earlier studies, her results implied that the I^{131} in this dose compares to a single dose of 1100 r, in its ability to inhibit thyroid hyperplasia. There was a close parallellism between the effect of the x-rays and I^{131} in the adenoma production and carcinoma production when followed by the administration of methylthiouracil for 15 months. Doniach[8] believed that the carcinogenic danger of radiation therapy was due to the production of irreversible cell changes in the thyroid which render them more liable than normal cells to tumor production when stimulated to undergo hyperplasia. Doses great enough to interfere with thyroxine synthesis by radiation damage to the thyroid lead indirectly to prolonged increased output of thyrotropic hormone from the pituitary and perpetual stimulus to hyperplasia of the thyroid cells.

Daily small doses of thyroid hormone partially replace endogenous thyroid hormone secretion and thereby lower T.S.H. output. This treatment applied to patients whose thyroid has been irradiated, intentionally or inadvertently, might reduce the likelihood of subsequent thyroid carcinoma. Doniach has suggested that the length of time of thyroid medication could be assessed by blood or urine estimations of thyrotropic hormone levels after a trial period of a few weeks cessation from medication.

One may ponder this when giving radiation therapy to patients with Hodgkin's disease involving sites near the thyroid. In particular the large doses currently employed may make thyroid administration as a prophylactic measure especially pertinent. Perhaps further investigation in animals should precede trial in human beings.

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Experience of a Coronary Care Unit: 1966-1971

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ONE OF THE MOST CHALLENGING and satisfying experiences in the past decade for practicing internists has been the opportunity to participate in the development and utilization of coronary care units (CCU). From its inception in a community hospital to the rapid dissemination of this concept by numerous meetings, conferences, and in the medical literature, there resulted an increased education and performance of physicians and nurses in the care of the patient with an acute myocardial infarction. Much of the mystery in management and the "Russian roulette" prognosis of myocardial infarction was changed to a firm scientific footing, enabling the practicing physician to become actively involved in a form of clinical investigation at the bedside. The array of arrhythmia detectors and electronic equipment that became immediately available lead initially to much of the physician interest. As data became available and was analyzed, the CCU concept rightfully spread to most hospitals affording primary patient care.

The success of the coronary care unit was founded on basic ground work of medical research and clinical observation, each being a necessary cog for the application to patient care. In the five years or so preceding this concept, many important advances occurred. Initially, closed chest cardiopulmonary resuscitation became effective and could be initiated by non-surgical personnel. The use of DC precordial countershock in treatment of ventricular fibrillation became available next, and it was discovered that this was the fatal arrhythmia in one third of the patients dying of myocardial infarction. Subsequently, the detection of life threatening arrhythmias occurring early in myocardial infarction, namely, ventricular premature beats, and their effective control by the use of intravenous lidocaine, became recognized. This drug became so successful that the emphasis on resuscitation in the unit soon became focused on prevention. The frequency and potential hazards of bradyarrhythmias were next to appear on the scene with their successful treatment with atropine and isoproterenol. Congestive heart failure occurred in nearly 50% of patients in early myocardial infarction, and the proper employment of rapid-acting digitalis preparations came into use along with the proper employment of parenteral antiarrhythmic agents. The rapid availability of sophisticated monitoring electronic equipment, which was necessary for early diagnosis, helped to detect these arrhythmias.

The most important factor of all was the institution and acceptance of coronary care nurses, often referred to as "soft ware," that helped produce the better care and prognosis, making the venture a success. Physician and nursing education, in their mutual desire to upgrade their respective performance in the diagnosis and treatment of electrocardiographic abnormalities and arrhythmias, has no doubt been one of the chief benefits of this experience. The impetus for these improvements in patient care originated not so much in the major medical centers and academic institutions, as it did with medical practitioners interested in clinical research and entrusted in the emergency care of patients with acute myocardial infarctions.

Madison General Hospital, a community hospital of approximately 500 beds, began with a single bed unit in May of 1966, and developed through many learning experiences and growing pains, with attending staff, house staff, and nurses, to become a six bed unit in January of 1967. The unit is an integral part of the Madison General Hospital–University of Wisconsin Medical School affiliation, with patients primarily cared for by internal medicine residents, interns, and fourth year medical students. The attending staff consists of approximately 30 internists, each taking full responsibility for patient care in cooperation with the house staff. No statistics are available for the year 1967, as reporting was then cumbersome, and left to the attending physician. These reports were difficult to obtain, if at all, and when compiled at the year's end, were subsequently discarded, as it became impossible to verify diagnoses and results by using charts alone. Beginning in 1968 data was gathered and compiled on a weekly or monthly basis by the chairman of the unit and the CCU nurse while data was fresh at hand, and readily examined and documented. In all cases, myocardial infarctions (MI) were diagnosed by ECG, enzyme rise, or post mortem findings.

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TABLE 1

Year	Admissions	Myocardial Infarctions	Deaths	Mortality Rate	Elective Cardioversion	Temporary Pacer	Battery Replacement and Permanent Pacer
1968	378	146	21	14.3%	16	18	
1969	438	159	19	12.5%	20	13	9
1970	461	168	24	14.2%	20	7	14

In review of coronary care statistics it is necessary to define the ground rules in order to define results. In this series, all patients despite age or duration of stay in the unit, who died of a primary myocardial infarction, were included in mortality figures. We have not included patients who were discharged from the unit in good condition but died prior to leaving the hospital. One misleading pitfall, soon excluded, was the admission and tabulation of the majority of the emergency "Doctor Blue" patients, temporarily resuscitated throughout the hospital, and brought to the unit for terminal care. It was soon discovered that this practice had such a low salvage rate that the unit could be better utilized in caring for fresh infarction patients rather than terminal carcinoma, massive hemorrhage, CVA, pulmonary infarctions, and other medical emergencies.

Necessary factors for any unit to function requires much cooperation and these have been proven and often restated. These include:

(1) Administrative cooperation and financing.
(2) Enthusiastic medical attending staff.
(3) Coronary care nurses who are accepted as part of the team.
(4) Constant and repetitive nursing and physician education in recognition and treatment of arrhythmias.
(5) Constant review of complications and causes of death.
(6) Dependable monitoring equipment with ready source of repairs and repairmen.
(7) Constant revision and review of treatment procedures.
(8) Outline and guideline criteria for admission and discharge.
(9) Detailed instructions and check lists for ready study and review by physicians not familiar with techniques; namely, cardioversion, use of transvenous endocardial pacing procedures.

Data concerning myocardial infarctions prior to 1965 is difficult to gather because most sudden and unknown causes of deaths occurring throughout the hospital were attributed to cardiac origin. Madison General Hospital was no exception, with information usually obtained from Medical Record data and had a generally accepted mortality rate of approximately 35%. This inhospital mortality rate has now been lowered by 50% in the last three years. Probably the most comforting aspect for the physician giving primary medical care for suspect coronary victims, is that he is now able to afford his patient positive treatment if he can be admitted to such a unit during the first hours after his infarction, where diagnosis and prognosis is now on a more firm ground, and complications are anticipated and promptly treated.

It is interesting to note (Table 1) that the total number of admissions and the number of those with myocardial infarctions have steadily increased in the last three years, although the number of available beds remains unchanged. It is a pleasure to report that in over 1200 admissions since the unit began, that it was necessary to intervene in less than 10 instances, where physicians could not agree on the priorities for admissions and discharges. It is extremely important to have these guidelines spelled out well in advance to circumvent these administrative difficulties. Frequently, the resident in attendance served as an arbitrator between physicians and determined who should be "bounced" and who should be admitted.

Since the beginning of the unit in 1966 through September 1970 only two head nurses were in charge. During this time, over 30 nurses were trained and rotated through this unit. The cooperation, esprit de corps, and constant review of their problems is a very necessary factor in the success of such a unit. Lecture and demonstration courses were given by the attending staff twice a year and there were also weekly conferences in reviewing the previous week's problem cases and complications.

FACTORS LEARNED AND TAKEN INTO REVIEW:

(1) Myocardial infarction is a late manifestation or endstage disease process, and as such CCUs do not answer the overall problem of coronary heart disease. Although the mortality rates of hospitalized patients with myocardial infarction have decreased by 50%, the largest total percentage (about 60%) of all MI patients never reach hospitals, and consequently the overall mortality is only reduced slightly. Myocardial infarctions may still appear as a first sign of coronary heart disease in almost 30% of the patients. These potential victims are still not recognizable by routine screening methods.

(2) Cardiac arrhythmias and complications occurring in the unit can be best recognized and treated by continued physician self-education, mutual discussion, and critical conference with peers. There should be constant review and sharing of experiences with the coronary care nurses as well, plus occasional

consultations with a cardiologist for better definition of problem solving.

(3) The concept of a detailed written outline of precise diagnosis and treatment of tachy- and brady-arrhythmias, conduction defects, congestive heart failure, and shock, ("cookbook medicine") does afford a beneficial learning and treatment experience in emergency care. This outline guide is especially useful when physicians may not be readily familiar with procedures and need a ready source of information. The concept of such a detailed outline may well be applied to other catastrophic experiences such as acute pulmonary embolic disease.

(4) Nurses can be trained to efficiently take and read electrocardiograms and use electronic equipment with exceptional accuracy and become exceedingly competent in patient care in critical situations; insert IVs and intracatheters, plus administer intravenous medications. A special category of recognition for their success in this field should be forthcoming.

(5) The initiation of prompt monitoring and insertion of a running IV in all MI suspects probably are the two most effective changes in the overall treatment. All other procedures rest on the groundwork that these two factors are in operation.

(6) The incidence of acute myocardial infarctions in a given population are variable in number from month to month, and for reasons yet unknown. At Madison General Hospital these range from 5 to 23 per month despite the number of suspect admissions. Because of this fact, units must be set up with some flexibility in the overall service of the hospital. In times of over-utilization, strict adherence to admission and discharge priorities must be practiced. We attempt to keep all proven cases of MI for at least three days in a unit and those with complications are kept for an additional three days after becoming stable from their last complication.

(7) Transvenous pacing is still one of the most perplexing problems facing noncardiologists responsible for patients in a coronary care unit. Although some institutions report an incidence of standby pacing in over 20%, our percentage has progressively decreased without change in patient survival. This difficult procedure should not deter, or be the determining factor in success or failure in any community hospital unit.

(8) Pump failure or shock still accounts for approximately 90% of the deaths occurring in our unit. Various methods to assist coronary circulation during the early critical hours are currently under investigation.

(9) Coronary arteriography and cardiac catheterization is now available at Madison General Hospital. This procedure is becoming increasingly necessary in the identification of patients with iatrogenic heart disease, atypical angina, pre-infarction angina, as well as in the study of patients after their infarctions for determining ventricular aneurysms or possibly myocardial revascularization correction. □

Hypercalcemia and Hyperthyroidism

By William P. Deiss, Jr., MD
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THE DETECTION OF HYPERCALCEMIA has become much more common in recent years. Physicians have become accustomed to looking for it among all patients with renal calculi, all those with demineralization of the skeleton, and many with difficult peptic ulcer disease. We should be attuned to screening even asymptomatic relatives of patients with hyperparathyroidism; and now that the serum calcium determination is included in many of the automated laboratory screening procedures, we are finding even more patients with asymptomatic hypercalcemia that demand explanation. Some of the causes that account for this abnormality are listed in Table 1.

It has become equally critical to appreciate the various clinical manifestations of serious, and at times, life-threatening hypercalcemia, to document the suspicion, and to render appropriate, and at times, life-saving therapy. The cardinal clinical features of such serious hypercalcemia attributable to the elevated serum calcium per se are listed in Table 2.

Hyperthyroidism is well known as a cause of elevated serum calcium. Baxter and Bondy[1] found 17 patients so affected among a group of 77 unselected hyperthyroid subjects. It is, however, quite uncommon for the hypercalcemia to reach levels that result in serious consequences for the patient. Parfitt and Dent[2] recently reported only 18 in their survey of the literature. Since many of the clinical manifestations of hypercalcemia (Table 2) are among those one might easily attribute simply to severe hyperthyroidism; it seemed appropriate to report here a patient we cared for, to emphasize that these two serious problems may co-exist and to permit opportunity to discuss therapy of such serious hypercalcemia.

Case Report. A fifty-one year old black female had been ill for two months with weakness, nausea, and occasional vomiting, and had experienced a 50-lb loss in weight. In another hospital she was studied and found to have a

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goiter, but a normal protein-bound iodine (PBI). Barium studies of upper and lower gastrointestinal tract and a gallbladder x-ray series were normal. Little additional history was obtained because of her apathy and general weakness. The temperature and respiration were normal but her pulse rate was 130/minute and the blood pressure 150/90 mm Hg. She was in moderate distress with nausea and vomiting but was well oriented. There was bilateral annulus senilis. Fundi were normal and there were no abnormal eye signs. The thyroid was diffusely and mildly enlarged (estimated weight—35 gm) and a faint bruit was detected. Lungs were normal. The heart was slightly enlarged to the left. An S_4 gallop and a grade III/VI systolic ejection murmur was heard, the latter transmitted to the left axilla. Pulses were bounding. Abdominal, pelvic, and rectal examinations were normal. The muscle mass was markedly decreased with severe muscle weakness in all extremities, but all deep tendon reflexes were hyperactive. There was a fine tremor of the fingers and her skin was smooth and soft.

The clinical impression on admission was that she had severe hyperthyroidism. Initial laboratory results showed a PBI greater than 20 μ/100 ml but the radioactive iodine (RAI) uptake was not elevated and the T_3 resin uptake was normal (32%). There was concern that the recent gallbladder dye study had invalidated the PBI and the isotope uptake study. Routine electrolytes were normal. The blood urea nitrogen (BUN) was 11 mg/100 ml. Hypercalcemia was noted on the initial day of hospitalization (see Figure 1 for relevant features of her course) along with persistent

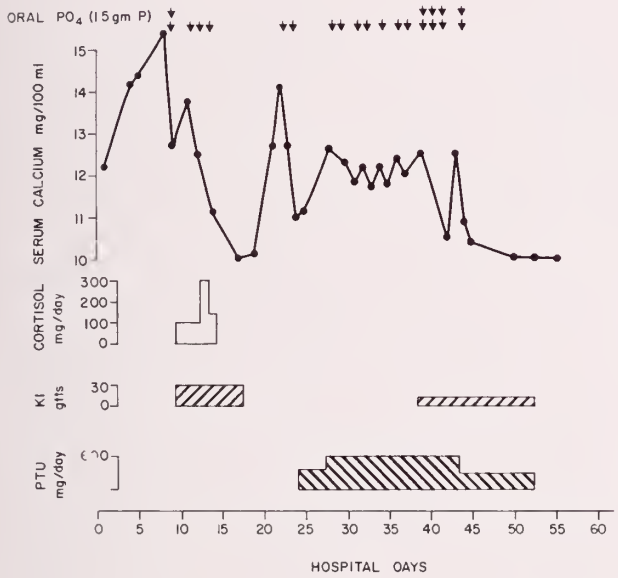

Fig. 1—Influence of treatment on serum calcium during hospital course.

TABLE 1—*Causes of Hypercalcemia*

Hyperparathyroidism	Hyperthyroidism
Hypervitaminosis D	Idiopathic of Infancy
Sarcoidosis	Hypophosphatasia
Milk-Alkali Syndrome	Acute Adrenal Insufficiency
Malignancies	Acute Osteoporosis
Without Bony Metastases	
With Bony Metastases	Post-Dialysis

TABLE 2—*Clinical Manifestations of Hypercalcemia*

1. *Central Nervous System*—Lethargy, Confusion, Coma
2. *Neuromuscular*—Weakness, Hypotonia
3. *Gastroenterology*—Anorexia, Weight Loss, Nausea and Vomiting, Constipation
4. *Renal*—Polyuria, Thirst
5. *Cardiac*—Short QT, T Wave Changes, occasionally Tachycardia

hypophosphatemia 2.2 to 3.0 mg/100 ml and a normal alkaline phosphatase 2.3 B&L units. A search for causes other than hyperthyroidism to explain the hypercalcemia yielded nothing of positive significance. Her skeletal roentgenograms were normal. No malignancies could be detected and sarcoidosis was not evident. Liver function was not abnormal. She was anemic with a hemoglobin level of 10.3 gm/100 ml. The white blood cell count and differential were normal. The electrocardiographic studies showed only sinus tachycardia with ST & T changes compatible with subendocardial ischemia.

By the eighth hospital day she had become progressively weaker and was extremely lethargic, confused, and stuporous. The serum calcium in spite of adequate hydration was 15.4 mg/100 ml; phosphorus, 2.2 mg/100 ml; and magnesium, 0.6 mg/100 ml. Intravenous fluids were increased to 5 liters per day; hydrocortisone was started, and because of our clinical impression of hyperthyroidism, potassium iodide solution was begun. In addition, oral phosphate was given (0.081 mole of Na, HPO_4 plus 0.019 mole KH_2PO_4 per liter to give a pH of 7.4), 500 ml of this solution providing 1.5 gm phosphorus. Within twenty-four hours she was much improved and by the thirteenth day she was lucid. On the seventeenth day the iodide was discontinued. One week thereafter repeat thyroid studies were again performed and the results substantiated the diagnosis of hyperthyroidism: T_3 resin uptake, 45%; and I^{131} uptake, 38% at four and 59% at twenty-four hours. At about that time (while she was not receiving iodine, steroids or phosphate) she was again noted to be lethargic and confused and the serum calcium level had risen to 14.1 mg/100 ml. Propylthiouracil was begun and phosphate was administered to control the hypercalcemia. This was effective in keeping the serum level around 12 mg/100 ml, although she remained quite weak. The pulse rate remained rapid (110–120/min), but with reserpine added to the regimen the rate was maintained at about 100/min. Small doses of iodide solution were instituted on the thirty-eighth day. Within a week she had improved markedly, the serum calcium remained normal without phosphate, and she was able to move about and regained strength and body weight. The pulse returned to normal without reserpine. She received a therapeutic dose of I^{131} shortly before discharge and had no exacerbation of hyperthyroidism or hypercalcemia. We have now followed her for two years and although a second therapeutic dose of radioiodine resulted in hypothyroidism, she remains in good health on replacement thyroid hormone. Repeated serum calcium determinations have been normal and her phosphorous is now normal.

Discussion. In this patient, hyperthyroidism, suspected on clinical grounds and eventually adequately documented, and serious hypercalcemia coexisted. While there was concern over the existence of various causes of hypercalcemia early in her hospital course, the major confusion was over the possibility that she had hyperparathyroidism in addition to hyperthyroidism. This combination of diseases has been recognized previously. It has been estimated[2] that 1 to 2 percent of patients with hyperparathyroidism also have hyperthyroidism which is a higher incidence than in the general population. The persistent hypophosphatemia suggested that this patient had hyperparathyroidism. The serum phosphorus values of the 23 patients collected from the literature with the two diseases coexistent were distinctly lower than in the 18 patients reported with hyperthyroidism complicated by hypercalcemia. It is also interesting that evidence of azotemia was greater in the latter group than in those with both

diseases and that our patient had a normal BUN. The only really decisive determination that would resolve the differential diagnosis is measurement of plasma parathyroid hormone. Levels would be elevated if there were a parathyroid adenoma and suppressed by the hypercalcemia of hyperthyroidism. Our patient's subsequent course, however, makes it most unlikely that she had a parathyroid adenoma since now that she is euthyroid, her hypercalcemia and hypophosphatemia have abated.

The mechanism of hypercalcemia in hyperthyroidism is unclear. It is very common for hyperthyroid individuals to have hypercalciuria (our patient excreted an excessive amount of calcium—200 to 280 mg/day), less common to have hypercalcemia[1] and rare to have severe hypercalcemia.[2] Bone turnover is well documented to be more rapid than normal in this disease. Bone resorption is elevated in such patients and our patient excreted an excessive amount of hydroxyproline peptide—87, 107, and 160 mg on the 35th to 37th day. It is not clear, however, why in some subjects the bone formation rate does not compensate. It has been suggested that any subject with a rapid bone resorption rate when immobilized is subjected to loss of the normal stimulus to bone formation provided by ambulation. Poliomyelitis, especially in the young, and Paget's disease when the patient is immobilized are examples of this phenomenon as such subjects may develop hypercalcemia. Patients with hyperthyroidism who become toxic enough or who have enough myopathy to be forced to bed may be in a similarly susceptible situation. The fact is that we do not have sufficient information to be specific in identifying the mechanisms of the hypercalcemia.

This patient is a good example of the necessity of directing therapy at hypercalcemia per se. There was little doubt that her clinical status deteriorated on two occasions when the serum calcium exceeded 14 mg/100 ml and that she experienced improvement, when on both occasions therapy resulted in lower levels. There are some general principles that are worthy of consideration in any such patient with serious hypercalcemia. There is usually dehydration and frequently hypokalemia resulting from excessive loss of water with the polyuria and from loss of water and potassium with the vomiting frequently present. Dehydration increases serum calcium, and hypokalemia and digitalis increase the cardiotoxicity of hypercalcemia. Intravenous rehydration and potassium repletion are therefore required. Since a high urine output of sodium is accompanied by an increased calcium excretion, it is important to include in the fluid-electrolyte replacement as much sodium as is otherwise feasible.

There are a variety of agents that can be used if, after adequate hydration and potassium repletion have been accomplished, the patient is still in jeopardy from hypercalcemia. Hydrocortisone can produce a satisfactory response in most patients with hypervitaminosis D, sarcoidosis, and of course, adrenal insufficiency, and in many with multiple myeloma and metastatic bone disease, especially breast cancer. The withdrawal of milk and alkali will result in a satisfactory response in the milk-alkali syndrome. Inorganic phosphate is probably the most widely used agent to obtain an acute response in many situations when additional therapy is necessary.[3] While it can be given intravenously, it is more prudent to use it orally if at all possible. It is now usually given in the latter manner in the form of Fleets Phosphate of Soda which contains 1.6 gm of phosphorus/10 ml. This is given in divided doses. Usually 10 ml/day will produce a calcium lowering effect. This agent acts by directly inhibiting bone resorption as well as by enhancing the deposition of new bone crystals at the expense of the serum calcium. We cannot be certain which of the three drugs—iodide, hydrocortisone, or phosphate—was responsible for our patient's initial response, but the second hypercalcemic crisis was aborted with phosphate.

The status of calcitonin[4] and furosemide[5] in various hypercalcemic crisis is still uncertain. There have been enough failures with the former to warrant pessimism for most cases. The latter carries some risks that will take further studies to evaluate.

Once the patient is out of danger from severe hypercalcemia, one must more accurately define the cause and make a specific attack on this basic abnormality, since in many patients it is possible to correct or at least modify the underlying cause. Parathyroidectomy for adenoma gives a very satisfying response when the tumor can be located. Withdrawal of vitamin D and the use of adrenal steroids until the effect of the stored vitamin abates is equally gratifying. We now know of certain malignancies that secrete parathyroid hormone-like polypeptides causing hypercalcemia. Kidney and lung are the most frequent of this group but ovary, uterus, pancreas, vagina, bladder, colon, and liver tumors have also been indicated. Removal of some of these tumors has corrected hypercalcemia and prolonged useful life. More frequently, neoplastic disease causes hypercalcemia by bony metastasis, but steroids and chemotherapy have resulted in successful palliation in some patients. There is a place for chronic control of hypercalcemia when a more definitive therapy is not available. This can be done with chronic inorganic phosphate or with cellulose phosphate.[6]

Summary. Hyperthyroidism can rarely produce serious life-threatening hypercalcemia. The hypercalcemia in such patients can manifest itself as protracted nausea and vomiting, weakness, lethargy and stupor, and excessive thirst and polyuria as in the patient reported here. In addition, in some such individuals the clue may lie in characteristic electro-

cardiographic abnormalities. The differential diagnosis may be difficult, especially in excluding coexistent hyperparathyroidism. Without the availability of parathyroid hormone assay of the blood, this differential depends upon producing a euthyroid state and determining whether the hypercalcemia disappears. Emergency medical attack upon the hypercalcemia is mandatory in this as in other critical hypercalcemic states. In this case the use of oral phosphate solution was helpful in maintenance until a euthyroid state was produced.

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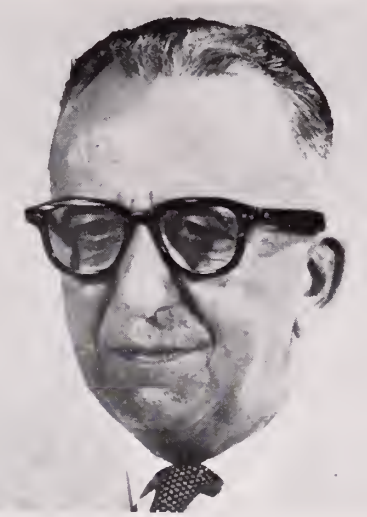

FIG. 5.1 **Ovid Otto Meyer**

OVID OTTO MEYER was born in Wisconsin, December 17, 1900. He received his B.S. from the University of Wisconsin and his M.D. from Columbia. He was an Intern and Resident at the University Hospital at Madison and Assistant in Medicine and Research Assistant at the C. P. Huntington Memorial Hospital at Harvard Medical School. In 1932 he went to the University of Wisconsin Medical School, and since 1944 has been Professor and Chairman of the Department of Medicine.

Doctor Meyer is a Fellow in the American College of Physicians. He is a member of the Association of American Physicians, the American Society for Clinical Investigation, the American Society for Experimental Biology in Medicine and the International Society of Hematology.

In September, 1940 when the potential significance of the use of Dicumarol became apparent, Doctor Meyer and his associates began their experiments with this agent. They established that the anticoagulant was a potent hypoprothrombinemic agent [illegible] in dogs and was without effect [illegible]. The first public report on their experiences with animals and man was given on February 27, 1941. Doctor Meyer and his group continued to experiment with oral anticoagulant agents, next using cyclocumarol and eventually warfarin sodium. They were among the first to observe that vitamin K_1 and vitamin K_1 oxide were effective antidotes for excessive hypoprothrombinemia produced by the coumarin anticoagulants.

Reproduction of recognition appearing in Clinical Anticoagulant Therapy *by Myron Vigran, published by Lea & Febiger, Philadelphia, 1965*

The Need for Data Bases in Therapy of Acute Leukemia and Lymphoma

By D. R. Korst, MD, P. C. Raich, MD, E. B. Crowell, Jr., MD
and L. L. Schloesser, MD, Madison, Wisconsin

In order that we can justify the continued use of more aggressive and complex therapeutic programs, and to answer questions concerning these regimens, it is imperative that all physicians and all patients with the diagnosis of leukemia and lymphoma should be entered into a data pool that produces meaningful results in as short a period of time as possible.

The basic research of Skipper, et al[1-3] in the transfer of tumor cells to susceptible animals and their response to chemotherapeutic measures suggests that a more aggressive approach and the use of combinations of drugs that have their effects on various sites of DNA synthesis will result in higher incidence and longer remissions. The controversy is unsettled as to whether the new programs in chemotherapy have resulted in a higher percentage of patients with longer survival.[4] The best answers appear to be coming from a cooperative organized approach by groups such as the cooperative groups in this country and the working parties in Great Britain[5] who collaborate to answer important questions.

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In certain stages of lymphoma it is unsettled as to whether radiotherapy or chemotherapy appears to be the initial program of choice.[6, 7] There appear to be important host factors that influence the course of the disease which make evaluation of therapy difficult and requires that cooperative studies be carried out on a *random* basis. For it is only the method of fair randomization of patients that can possibly result in two equal groups being compared in order to assess advantages of one mode of therapy over another.

Acute Leukemia. Since the advent of single and two drug combinations in the chemotherapy of acute leukemia 20 years ago, there seems to be a very slight improvement in survival, and the data suggests that there is indeed a great need for improvement.[8-10] Previous studies have failed to find any significant factor other than age and cell type that may influence a longer survival in acute leukemia in adults.

A series of 73 adult patients with acute leukemia was reviewed at Doctor Ovid O. Meyer's clinic at the University Hospitals from the period 1959 through 1970. In this group of patients 26 had acute granulocytic leukemia or monocytic leukemia and 47 patients had acute lymphocytic leukemia. The mean age was 40 years and the mean survival in months was 3.5. Twenty-three of these patients survived six months or longer and this was the younger group with a mean age of 27 years who were predominantly lymphocytic type. An analysis of eight patients who survived 12 months or longer is shown in Table 1. A longer survival could be predicted on the basis of those younger patients who had lymphocytic leukemia although there was not a consistent common denominator. Most patients had an acute onset of leukemia and those who had a good remission had variable prodromata from minimal symptoms and changes in blood counts to those with rather severe symptoms and changes. A good remission induced by the first chemotherapeutic program suggested that the patient might have a second remission on a change of therapy.

The results of this study, as in previous studies reported, suggested there are few predictors of 12 months or longer remission in acute leukemia. The survival was plotted using the life table method[11] as shown in Figure 1. The differences between acute lymphocytic and acute granulocytic (including monocytic) is apparent. The most accurate data appears to be from the time that the diagnosis was established; however, if one looks at the data of survival from the onset of symptoms by history (Fig 2) the curve is slightly different but only with an increase in mean survival to 4.5 months. The overall outlook in acute leukemia is therefore very grim and clinical research in new therapeutic approach is necessary.

This type of data provides a basis to compare newer modes of therapy. A Wisconsin group of hematologists has been organized for two years. The Wisconsin Hematology Study Group is presently evaluating two current treatment programs for adults with acute leukemia.[12-14] The acute leukemia protocol compares the four drug VAMP program utilizing vincristine, methotrexate, mercaptopurine, and prednisone for induction of remission and

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TABLE 1—*Patients with Acute Leukemia Who Experienced Remission of 12 Months*

Patient	Age	Sex	Duration of Remission	Therapy	Diagnosis	AT ONSET		
						Hemogram	Differential	Marrow
1	27	F	12 mos. No second remission	MTX + PRED — 1 6MP — 2	ALL, acute onset, fever weight loss	Hct. 26% WBC 43,000 Pl: low	57% lymphs 34% blasts	Hyperplastic Lymphoblastic
2	21	F	13 mos. Good second remission	MTX + PRED + 6MP — 1	ALL, acute onset, fever	Hct. 33% WBC 5,100 Pl: normal	34% lymphs 55% blasts	Hypercellular Lymphoblastic
3	15	M	14 mos. Partial second remission	MTX + PRED — 1 6MP — 2 Cytoxan® — 3	AGL, acute onset, weakness, bleeding	Hct. 19% WBC 3,900 Pl: 15,000	42% PMN 1% metamyel. 6% blasts	Hypercellular 5% blasts
4	21 Congenital Defects	M	20 mos. Never a good remission	6MP — 1 MTX — 2	ALL, gradual onset, bone pain	Hct. 28% WBC 1,600 Pl: decreased	21% lymphs 20% blasts	Dry Tap
5	20	M	12 mos. Good remission	MTX + PRED — 1	ALL, gradual onset, fever weakness	Hct. 22.5% WBC 1,600 Pl: Absent	76% lymphs	Dry Tap Lymphoblastic on biopsy
6	31	M	12 mos. Partial second remission	MTX + PRED — 1 6MP — 2	ALL, acute onset, lymphadenopathy	Hct. 34% WBC 169,000 Pl: decreased	96% blasts	Hypercellular Lymphoblastic
7	18	M	20 mos. Three good remissions	6MP + PRED — 1 MTX — 2 Cytoxan® — 3	ALL, acute onset, dyspnea, hip pain	Hct. 23% WBC 2,300 Pl: 31,000	66% lymphs 8% blasts	Dry Tap Lymphoblastic on biopsy
8	17	M	14 mos. Good remission	6MP + PRED — 1 MTX — 2	ALL, acute onset, leg weakness, bleeding	Hct. 30% WBC 1,900 Pl: 49,000	76% lymphs 14% blasts	Hypocellular Lymphoblastic

KEY: Methotrexate = MTX
Prednisone = PRED
6-Mercaptopurine = 6MP

ALL = Acute lymphocytic leukemia
AGL = Acute granulocytic leukemia

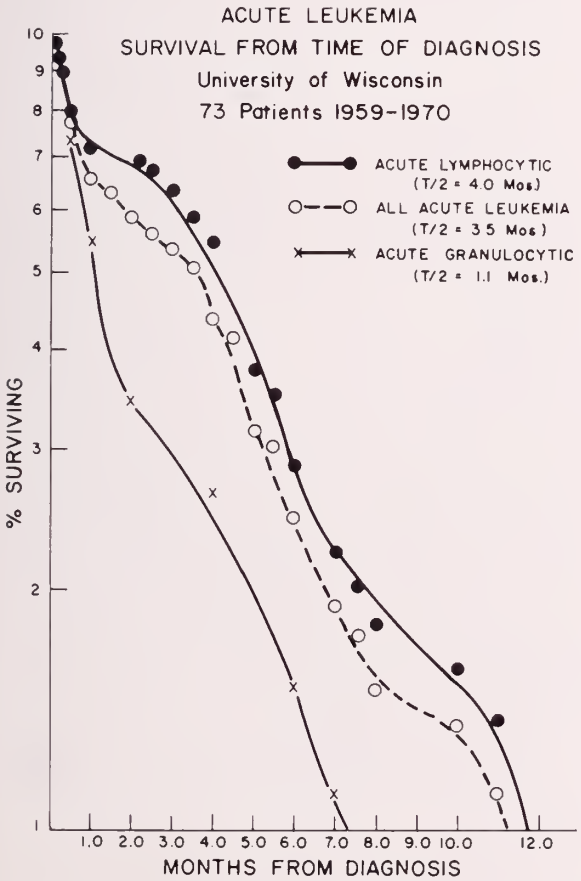

Fig. 1—Survival in adults with acute leukemia on semi-log plot from 100% to 10% by cell type. Eight patients who survived 12 to 20 months are listed in Table 1.

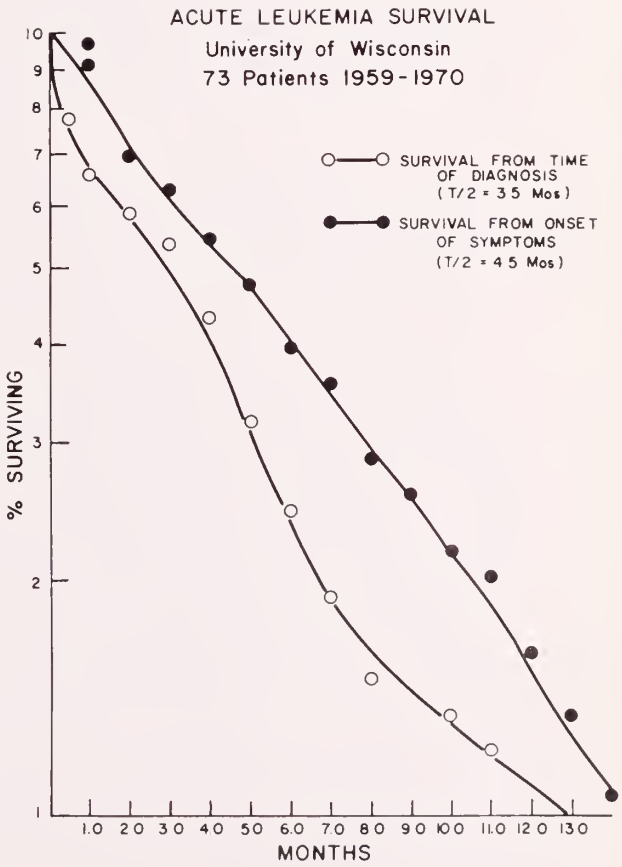

Fig. 2—Survival of adults with acute leukemia plotted from 100% to 10% comparing data from time of diagnosis and time of onset of symptoms.

maintenance therapy with mercaptopurine versus a more intensive regimen utilizing cytosine arabinoside and thioguanine. Approximately 60 patients have been entered into this study to date.

Lymphoma. The data base in lymphoma is more variable. A National Institutes of Health protocol using the combination of nitrogen mustard, vincristine, procarbazine, and prednisone has shown an increased induction of remission with a longer sustained remission in a significant number of patients with advanced Hodgkin's disease, lymphosarcoma, and reticulum cell sarcoma.[15, 16] These studies provide references to older data but do not have a random control group in the study. Prior data from the experience of O. O. Meyer at University Hospitals[17] and data presently being gathered on long-term survival in Hodgkin's disease will also be helpful as the data base. A review of current literature does not reveal any of the studies of quadruple cyclic therapy programs being compared in a random fashion with current standard therapy. Therefore, the Wisconsin Hematology Study Group has presently undertaken to compare chemotherapy of lymphomas involving one or two drugs versus a four drug program given in two week cycles for a total of six cycles over a six month period. (The COPP program of cyclophosphamide [Cytoxan®], vincristine [Oncovin®], procarbazine, and prednisone). Approximately 100 patients have been entered into this protocol to date.

Summary. New therapeutic regimens in leukemia and lymphoma are generally more aggressive forms of therapy involving multiple drugs and usually require more time in the hospital for the patient and a closer monitoring by the physician and the laboratory. There is a need to compare these two programs with current standard forms of therapy that will require more patients being observed in a cooperative fashion and involve all physicians in providing data that can be evaluated in several years time. A data base is provided by the medical literature and the current review of results in therapeutic programs over the past 20 years. In order to answer these vital questions a Wisconsin Hematology Study Group has been formed for the purpose of involving more patients and more physicians in gathering the information.

THE WISCONSIN HEMATOLOGY STUDY GROUP INCLUDES:

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☐ *Some patients who do not have any illness known to be causative of or related to vitamin B12 deficiency believe that frequent injections of the vitamin are beneficial. In a randomized double blind study, 2 such women received weekly injections of vitamin B12 or phenolsulfonphthalein (PSP). Subjective responses to these injections were scored 7 days after the injection. No difference was perceived between B12 and PSP.*

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Is Vitamin B12 a Tonic?

By Robert F. Schilling, MD and Frances K. Morris, MS
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REPEATED AND FREQUENT injections of vitamin B12 are commonly given by physicians for a variety of conditions which are not known to be related to pernicious anemia or other forms of vitamin B12 deficiency. Some patients are of the opinion that the vitamin B12 injections are genuinely helpful. Some physicians believe that some of their patients are helped by the use of vitamin B12 injections as a tonic or general beneficial agent.

Using a randomized double blind study, we have tested the value of frequent vitamin B12 injections in two patients who believed that such injections were helpful if given weekly.

PATIENTS AND METHODS

(A) Patient 1, age 64 and married, and Patient 2, age 67 and single, are intelligent, educated ladies who have performed well in middle America. They were being given injections of vitamin B12 every one or two weeks by their physicians for symptoms of fatigue and nervousness. Each was demonstrated to have acid gastric juice by the Diagnex Blue® technic, and after the completion of this study each was shown to have normal vitamin B12 absorption by the urine radioactivity technic.[1] Neither patient had previous surgery on the gastrointestinal tract.

(B) With understanding in advance and consent from these two patients, we arranged for a 25-week randomized double blind comparison of the effect of injections of either vitamin B12 or phenolsulfonphthalein (PSP) dye of color to match the vitamin B12 solution. With the help of a colleague, vials of sterile material were prepared and labelled A and B. One contained B12 and the other PSP. An injection was given each week by one of us only after the patient had filled out the following questionnaire concerning the effects of the previous injection.

DATE _____

(1) When did you have last injection? _____
(2) Did it harm you? (yes or no)
(3) Did it help in general (0–4+)
(4) If "yes", how long? (1–7 days)
(5) Did it benefit you as regards? (yes or no)

Energy _____
Pep _____
Strength _____
Depression _____
Nerves _____
Appetite _____
Tremor _____
Fatigue _____
Outlook _____

(6) Did you need an injection of B 12 today?

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Supported by a research grant from the National Institutes of Health.

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TABLE 1—*Questionnaire Responses*

Question	Patient 1		Patient 2	
	B12	PSP	B12	PSP
(2) No harm from injection	9 11	12 13	13 13	12 12
(3) Average benefit (0–4+ scale)	2.72 ± 1.85*	3.69 ± 0.75	2.15 ± 1.14	1.67 ± 1.37
(4) Average duration of benefit (0–7 days)	4.09 ± 2.91	4.92 ± 2.02	2.92 ± 2.43	3.25 ± 3.17
(5) Average number of improvements	5.73 ± 3.69	7.46 ± 1.19	7.61 ± 1.12	6.83 ± 1.80
(6) Yes, I need injection	11 11	13 13	12 13	12 12

*± 1 Standard deviation.

Neither the authors nor the patients knew the contents of the vials until after the completion of the study. The decision to inject A or B was made by drawing a random number.

After the last injection and report of its effect, the code was broken and the numerical results tabulated to see if there was any difference in the response to B12 injections as compared to PSP injections. The vitamin B12 solution injected into Patient 2 contained 1000 μg/ml and that given to Patient 1 contained 200 μg/ml.

The responses to question 2 through 6 are shown for each patient in Table 1, and it is clear that these patients do not perceive a difference between vitamin B12 and PSP under these conditions. "T" tests[2] of the significance of the differences between the mean response to B12 and to PSP for questions 3, 4, and 5 in each patient indicate that the observed differences might well have occurred by chance.

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Acute Adrenal Insufficiency Secondary to Anticoagulant Therapy

By William H. Dreher, MD, John H. MacIndoe, MD, George E. Magnin, MD, John N. Browell, MD, Thomas F. Nikolai, MD, and Francis N. Lohrenz, MD, Marshfield, Wisconsin

ACUTE ADRENAL INSUFFICIENCY caused by hemorrhage due to anticoagulant therapy usually is lethal. To date, 39 patients have died soon after its onset, and only 4 have survived such an event. Our report adds one more case to the total (now 44) and adds one more patient to the survivors (now 5). (An addendum to this paper includes another case.)

The patient's life depends on early diagnosis and prompt treatment. To this end, we strongly suggest that plasma cortisol be measured *before* large doses of steroid are administered to control hypotensive and febrile episodes associated with use of anticoagulants.

OVID O. MEYER

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From the Marshfield Clinic and the Marshfield Clinic Foundation for Medical Research and Education.

Doctor Dreher is a Resident and Doctor MacIndoe is an Intern, Internal Medicine, University of Wisconsin Medical School, Madison (Marshfield Teaching Service).

Doctor Magnin is in the Department of Medicine, Marshfield Clinic, and Director, University of Wisconsin Department of Medicine Teaching Service.

Doctor Browell is in the Section of Cardiology and Doctors Nikolai and Lohrenz are in the Section of Endocrinology, Marshfield Clinic, Marshfield.

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Case Report. A 56-year-old lawyer received warfarin sodium (Coumadin®) from the date of his myocardial infarction in 1967 until August 25, 1969. On September 3, 1969, the patient came to St. Joseph's Hospital in Marshfield, Wisconsin, having suffered pain and coldness in his right foot for three days. The pain involved the plantar surface near the toes and persisted during rest. All the right toes were blue and were cooler on palpation than the left. Petechiae were noted on the right foot. Edema was absent.

The patient had no history of intermittent claudication, recurrent chest pain on exertion, or recent arrhythmia. Temperature and pulse were normal. The blood pressure was 128/70 mm Hg. The right popliteal pulse and right dorsalis pedis pulse were decreased, but the posterior tibial pulses were readily palpable right and left. Heparin, papaverine, and low-molecular-weight dextran were administered for an arterial embolus to the right leg.

On the ninth hospital day (Sept. 11) the patient became weak. He developed nausea Sept. 12, developed acute anorexia Sept. 13, became febrile (rectal temperature 102.6 F) on Sept. 14, and began vomiting Sept. 14. The next day (Sept. 15) the rectal temperature rose to 104.4 F, blood pressure decreased to 60/50 mm Hg, and the lethargy and confusion of the previous days prevailed. The pulse was 120 beats per minute. Heparin was discontinued.

Septicemia and further embolic disease was considered. Antibiotics (gentamycin and cephaloridine), Solu-Cortef® (hydrocortisone sodium succinate) every six hours, and Aramine® (metaraminol) were administered. Nine hours later, rectal temperature was normal and blood pressure was 110/80 mm Hg. After the patient had remained stable for 48 hours, cephaloridine and steroids were discontinued (noon Sept. 17) on the fifteenth hospital day.

Table 1—*Clinical Course of Patient with Adrenal Hemorrhage Secondary to Anticoagulant Therapy*

DATE	SEPT. 12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	OCT. 1
TEMPERATURE (F) (Rectal)	104 F / 102 F / 100 F			9 AM / 8 PM	2 PM				8 AM / 1 PM						10 PM	1:30 PM			
BLOOD PRESSURE (mm Hg)	141/100		120/70	110/80 / 60/50	110/80	120/80	110/80	100	100/80 / 80/60	100/80	140/80 / 96/60	101/60	150/90	150/90	110/70	100/70 / 70/50	110/70	110/80	110/70
LEE WHITE Sept. 3 Baseline = 10′ Sept. 3 Sept. 12 = 16′–22′	24′	25′		13′	9′				19′	15′								13′	
HGB (gm %)			16.9	17.2	16.6		13.2		15.3		11	10.7		10.3		13.3		10.2	11.3
PLASMA CORTISOL[3] (fluorogenic steroids) mcg 100 ml															5 / 3				
Na + (serum)				133	137				125	131		142		140		128	133	132	138
K + (serum)				4.6	4.4				5.2	5.2		4.7		3.1		4.0	4.0	1.5	4.2
HEPARIN (Begun Sept. 3)				2 AM / 9 AM			Noon									4:30 PM			
CORTICOSTEROIDS			Solu-cortef® 500 mg q6h													100 mg Push			

Table 2—*Adrenal Function During Hydrocortisone Therapy, 10 mg Four Times Daily*

Date	Sept. 26	Sept. 30	Oct. 1	Oct. 2	Oct. 3	Oct. 4
Cortisol (serum) (mcg/100 ml)	AM = 3.0 PM = 5.0	PM = 26	PM = 29	PM = 25	PM = 26	
ACTH IV				80 units IV in 8 hr	80 units IV in 8 hr	
Hydroxycorticosteroids (mg/24 hr)		9.0	10.8	9.5	12.9	11.0
17-Ketosteroids (mg/24 hr)		12.4	7.2	6.3	6.8	7.2
Sodium (mg/24 hr)		211	270	267	222	156
Potassium (mg/24 hr)		64	65	64	70	58
Creatinine (Gm/24 hr)		1.1	1.2	1.3	1.2	1.1

About 36 hours later (Sept. 19), fever recurred and intractable hiccups developed. Heparin and cephaloridine were given for about 12 hours. Following their withdrawal at noon Sept. 20 the patient's rectal temperature spiked to 104 F and remained high for 24 hours. The serum sodium was 125 mEq/L. Blood pressure remained normal until 11:00 PM when it decreased to 80/60, whereupon Aramine® increased it to 100/80. At 8:00 AM Sept. 21 rectal temperature was 103 F. At 11:00 AM Solu-Cortef® was given again, 500 mg every six hours. The patient was still receiving antibiotics and Aramine®; digoxin was now added. By 4:00 PM pulse and temperature were normal, blood pressure was stable, and serum sodium was 131 mEq/L.

Meanwhile the right foot had become increasingly more cyanotic and painful and, by now, was gangrenous. Septicemia from gram-negative organisms was suspected, but blood, urine, and sputum cultures contained no pathogens.

On Sept. 22, the patient's twentieth hospital day, the right leg was amputated. Intravenous steroids were given during surgery and until the next morning (Sept. 23).

On Sept. 25, about 40 hours after withdrawal of Solu-Cortef®, unremitting hiccups recurred along with anorexia and nausea. One day later (Sept. 26) the patient's temperature rose to 104 F, and his pulse increased to 120. Blood pressure was relatively stable at 110/70 mm Hg, but vomiting began. All antibiotics had been discontinued, but a Sept. 24 urine was now reported positive for Klebsiella, so oral tetracycline was begun. Plasma cortisol was 3.0 mcg/100 ml (AM) and 5.0 mcg/100 ml (PM) at this time. A chest film revealed bilateral pleural effusions, a lung scan showed bilateral perfusion defects, and a pulmonary angiogram revealed multiple small emboli.

Next afternoon (Sept. 27) the patient suffered three hours of steady diarrhea, hiccups, and vomiting along with increasing lethargy and intermittent confusion. By this time his temperature had spiked to 105 rectally, his pulse was 120, and his blood pressure was 70/55 mm Hg. A spinal tap was negative. One unit of whole blood was followed by 100 mg of Solu-Cortef® by intravenous "push". These returned the temperature to normal and the blood pressure to 100/70 within six hours.

On Sept. 28 we started oral hydrocortisone, 10 mg every six hours, and intravenous heparin. The patient has been well since.

TABLE 3—*Adrenal Function Values (Five Months After Adrenal Hemorrhage Secondary to Anticoagulant Therapy)*

Date	Jan. 12	Jan. 13	Jan. 14	Jan. 15	Jan. 16
Cortisol (serum) (mcg/100 ml)	8 AM —4.0 12 Noon—3.5 5 PM —3.5				8 AM —2.5 12 Noon—2.5 5 PM —2.0
ACTH IV	40 units in 4 hr				40 units in 4 hr
ACTH IM		80 units b.i.d.	80 units b.i.d.	80 units b.i.d.	
Dexamethasone 0.75 mg orally	←				→

Table 1 summarizes the patient's clinical course through Oct. 4, the thirty-third hospital day.

We took note of the patient's acute fevers, his episodes of sudden hypotension, his hemoconcentration, hyponatremia, and water loss, all in the absence of bacterial pathogens. Also, we took note of a common denominator, namely, the patient's responsiveness to steroids. Accordingly, our provisional diagnosis was adrenal insufficiency, and with the patient still on oral hydrocortisone, we attempted to evaluate this as shown in Table 2.

Plasma cortisols[11] were determined daily at 5:00 PM. At the same time, total urinary hydroxycorticoids[12] and 17-ketosteroids[13] were measured for two days for basline values. Subsequently, on two consecutive days, 80 units of aqueous ACTH in eight hours was administered, causing no increase of plasma or urinary steroids during the two days of stimulation or the subsequent days. Sodium excretion equal to 211, 280, 267, 222, and 156 mEq daily prompted us to change from hydrocortisone to fluorohydrocortisone, 0.05 mg every other day. The patient's continued improvement allowed his discharge on Oct. 25 after 52 days in the hospital.

On Jan. 11, 1970, the patient was admitted for reevaluation of adrenal function and fitting of prosthesis for his right leg. Hydrocortisone, 10 mg four times daily, and fluoro-hydrocortisone, 0.05 mg every other day had been discontinued five days before. Dexamethasone, 0.75 mg daily, during this time was substituted. The patient had been maintained on Coumadin®, felt well, and had no further episodes of fever, hypotension, or ischemic disease.

Table 3 records the plasma cortisol values of an intravenous ACTH test before and after maximal adrenal stimulation. This showed evidence of permanent adrenal insufficiency. He was discharged Jan. 17, 1970, to take hydrocortisone, 20 mg at 8:00 AM and 10 mg at 2:00 PM, as maintenance dose.

The published literature. Verdonk[1] first reported a case of adrenal hemorrhage secondary to anticoagulant therapy. Thorn et al[2] reported hemorrhagic adrenal insufficiency when they reviewed the treatment of adrenal dysfunction in 1956. The anticoagulant in each report was heparin. In 1958 Chokas[3] recorded the first case of adrenal hemorrhage during Dicumarol® (bishydroxycoumarin) therapy (for myocardial infarction). In 1966, McDonald et al[4] reviewed 25 cases of adrenal hemorrhage in the English literature, 10 in the non-English literature, and 6 of their own. The report by Klassen and Murphy[5] brought the total cases to 43, and our report adds one. (See addendum for one more case.) In the 39 deaths, diagnosis was established by post-mortem examination of the adrenals. The previous four survivors all developed Addison's disease in the absence of steroid maintenance.

Discussion. Our patient seems to fit the description of previous cases. Thirty-one of 41 patients reviewed by McDonald et al[4] were 60 or more years old. All received heparin for some portion of their clinical courses, but 3 of McDonald's own patients were treated primarily with Dicumarol®. Onset of symptoms followed 2 to 22 days after initiation of anticoagulant therapy, the average being 8 days.

Our patient's first episode of hypotension, hyperpyrexia, and hyponatremia occurred 12 days after the beginning of heparin therapy, although long-term Dicumarol® had preceded this. As well as could be determined by clotting studies, there was no general evidence of bleeding or indication that anticoagulants had been increased to the point of bleeding in tissues generally.

Deaths presumed due to adrenocortical suppression following corticosteroid therapy have been reported frequently.[6-9] Relatively few reports, however, include reliable estimates of plasma steroids. Unrecognized blood loss, myocardial infarction, and septicemia also produce a similar picture: and large doses of hydrocortisone will often raise the blood pressure by direct inotropic action on the heart and by other non-specific effects.[10] Our patient received large doses of steroids for the initial two episodes of hypotension, hyponatremia, and hyperpyrexia. Symptoms did not recur during maintenance therapy with hydrocortisone.

The reevaluation of adrenal function five months after the diagnosis of adrenal insufficiency indicates that there was no significant return of adrenal reserve. This is consistent with other patients reported with adrenal crisis due to anticoagulant therapy, and suggests that adrenal hemorrhage, when it occurs, is generalized and causes a permanent endocrine defect.

Addendum to Report

Second Case Report. A 50-year-old white male well-driller, who had had insulin-dependent diabetes mellitus since 1955, was admitted to the hospital on Nov. 11, 1970. Fourteen days prior to admission the patient had symptoms consistent with a mild upper respiratory infection. Eleven days before admission he had an episode of severe coughing and became unconscious. He was admitted to another hospital where hypoglycemia was established as the cause of his unconsciousness, with quick response to the administration of glucose. A chest x-ray showed an infiltrate in the right lung field consistent with a pulmonary infarct. He was placed on intravenous

heparin which was discontinued two days before transfer to St. Joseph's Hospital. Coumadin® (sodium warfarin) therapy was instituted with the cessation of heparin. Three days before admission, his temperature rose to 102 F and he developed persistent epigastric and upper abdominal pain, generalized malaise, and a few mild insulin reactions.

Examination on admission revealed a blood pressure of 110/70 mm Hg, temperature 101 F, pulse 96 and regular, and a huge hematoma 25 to 30 cm in diameter over the lateral aspect of the right buttock. There was a small central area of skin necrosis at the site of a previous intramuscular injection.

Electrocardiographic studies revealed a sinus rhythm with a rate of 90 and diffuse T-wave inversion in the limb and lateral chest leads. A chest x-ray film showed a small pulmonary infiltrate in the right medial lung base but an I–131 aggregate lung scan showed no evidence of perfusion defect. The hemoglobin level was 14.9 gm/100 ml, hematocrit reading 43%, white blood cell count 10,500 per cu mm, with a differential count of 47 segmented neutrophils, 46 lymphocytes, 5 mononcytes, 1 eosinophil, and 1 basophil; prothrombin time 19.5 seconds (control 12 seconds); urinalysis, 150 mg albumin, ½% glucose, and blood urea nitrogen 17 mg/100 ml.

On the morning after admission an upper gastrointestinal x-ray series and oral cholecystogram showed nonvisualization of the gallbladder, mild gastric retention, and considerable deformity of the antral and pyloric portions of the stomach felt to be consistent with pyloric obstruction probably due to duodenal ulcer disease. It was then noted that the patient's temperature was 103 F, pulse 102, blood pressure 90/60 mm Hg. He developed profuse diaphoresis. Within two hours his blood pressure had dropped to 60/0 mm Hg, pulse 150 per minute, and temperature 104 F. His serum electrolytes revealed a serum sodium of 102 mEq/liter, chloride 86 mEq/liter, potassium 4.2 mEq/liter. A plasma cortisol (Mattingly[11]) was 3.5 mcg/100 ml. A tentative diagnosis of acute adrenal insufficiency secondary to recent adrenal hemorrhage from anticoagulant therapy was made and the patient was given 100 mg of Solu-Cortef® intravenously. The rate of intravenous normal saline infusion was increased. There was a dramatic prompt clinical improvement within two hours and the vital signs returned to normal within four hours. Cortisone acetate was administered intramuscularly and orally; and he remained well for the next five days. During this period he had occasional mild hypoglycemic reactions responding to oral intake of food. On Nov. 17 the patient had a sudden onset of right-sided facial weakness, hemiparesis and hemianesthesia, and homonymous hemianopsia. Within six hours he was in deep coma. He died within 24 hours.

An autopsy revealed a massive left intracerebral hemorrhage as the cause of his death.

His prothrombin time was 15 seconds (control 12 seconds) and remained at this level until his death, although no further anticoagulant therapy was given. The adrenal glands revealed massive bilateral intra-adrenal hemorrhage (Fig 1).

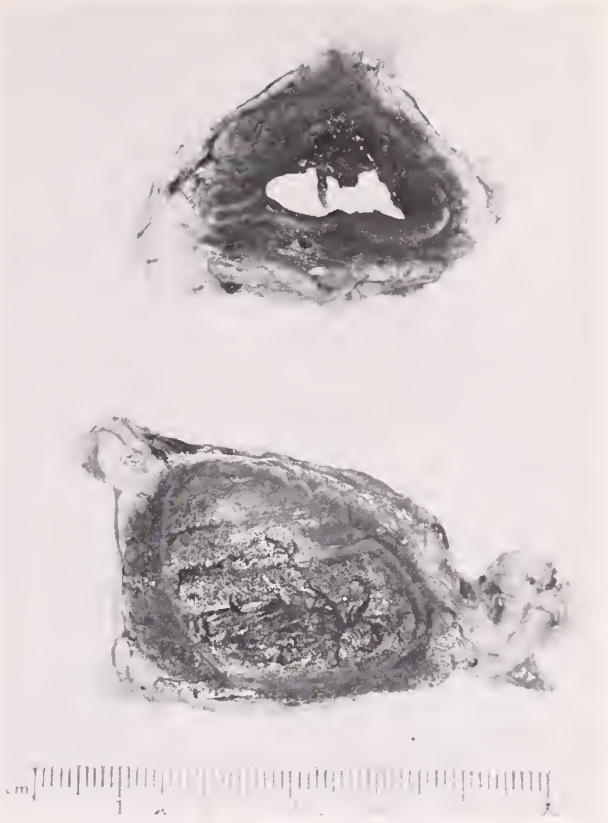

Fig. 1—Adrenal glands found at autopsy showing massive hemorrhage bilaterally. The right adrenal gland appears in the upper portion of the photograph and the left adrenal gland in the lower portion.

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Internship:

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Faculty Appointments:

1932–37 Assistant Professor of Medicine, University of Wisconsin Medical School, Madison
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1950– Consultant in Internal Medicine to the Surgeon General of the United States, European Theater of Operation

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1964 University of Wisconsin Medical Alumni Class of '44 established program in support of "Research in Educational Methodology in Clinical Medicine"

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Central Interurban Clinical Club

Association of American Physicians

Association of Professors of Medicine

Society for Experimental Biology & Medicine

International Society of Hematology

Blood Club

Wisconsin Society of Internal Medicine

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COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

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The Use of Expectorants

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THE PHYSICIAN WHO TREATS pulmonary disease recognizes the medical importance and the degree of relief from cough and dyspnea afforded by the removal of thick, tenacious respiratory secretions. Traditionally, expectorant drugs have been used to remove these secretions. Modern expectorant therapy includes not only drugs but also any procedure which actively removes bronchial secretions from the chest. The dual nature of the clinical approach to expectorant therapy is shown in Table 1.

The modification of secretions includes the classical methods of hydration, the use of expectorant drugs, and the more recently employed direct chemical attack on secretions with mucolytic and wetting agents. Pharmacologically, expectorants are drugs which either modify bronchial secretions or act within the pulmonary system to allow for the easier raising of sputum. Formerly, an increase in the amount of sputum raised was the measure of an effective expectorant. Recently however, more emphasis is placed on decreasing the viscosity of intrabronchial secretions, permitting easier expectoration and also allowing the bronchial ciliary system to function in a more physiologic environment. Thus, a new criterion for the efficacy of expectorants is the decrease in sputum viscosity. However, commonly used oral expectorants have yet to be shown to decrease sputum viscosity. The proposition that decreases in sputum viscosity can be correlated with favorable results in each disease where expectorants are used has yet to be tested by controlled studies.

Clinical experience has shown that even effective mucus thinning may not be enough for seriously ill patients. The thinned secretions may have to be actively brought up by (1) bronchodilation which allows an adequate airstream to push the secretions towards the large bronchi, (2) deep breathing, (3) deliberate coughing, (4) postural drainage, (5) chest clapping, (6) tracheal suction and when necessary, (7) bronchoscopy. Since these procedures remove secretions from the chest, they must be included as expectorant measures. Expectorant procedures must be specific for each disease. The necessity for specific treatment requires familiarity with a large group of drugs. Table 2 lists and classifies expectorant drugs according to pharmacologic action, route of administration, customary adult dose, and common side-effects. Appropriate expectorant therapy will be discussed under the management of each illness.

TABLE 1—*Clinical Approach to Expectorant Therapy*

A. Modification of Secretions	B. Removal of Secretions
Hydration	Bronchodilators
Oral	Deep breathing
Parenteral	Deliberate coughing
Via aerosol	Postural drainage
Expectorants	Chest clapping
Mucolytic agents	Tracheal suction
Wetting agents	Bronchoscopy

Management. Airway obstruction from inspissated secretions may occur with pneumonia, laryngotracheobronchitis, acute and chronic bronchial asthma, acute bronchitis, chronic obstructive lung disease, bronchiectasis, the postoperative status, cystic fibrosis, tracheostomies, and prolonged bedrest. Dehydration is common to all of these illnesses and provokes thick, intrabronchial secretions. Here the most useful preventative expectorant measure is adequate oral and parenteral hydration and/or inhalation of water aerosols. Adequate hydration will not influence the viscosity of the mucus plug already formed. It is not known if newly formed mucus of low viscosity will "float off" a preformed plug. To be effective, inhaled aerosols must deliver small droplets (between 3 and 5 microns in diameter) to the peripheral bronchial tree over a long enough period of time. It has been shown that because of the hygroscopic nature of mucus, large amounts of water must be absorbed in order to decrease the viscosity only slightly.[1]

Pneumonia. In lobar pneumonia of a single lobe, oral expectorants, with the exception of large amounts of fluids, have not been shown to be of value. The most useful oral or parenteral "expectorant" in these cases is, of course, the correct

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TABLE 2—*Expectorant Drugs*

Classification	Agent	Route of Administration	Customary Dose	Side-Effects and Comments
Hydration†	Water	Oral Parenteral Aerosol therapy Room vaporizer Tent Nebulizer	1.5–2.5 L/24 hrs 2.0–3.0 L/24 hrs 8–12 L/24 hrs 2–4 L/24 hrs 20–60 ml/24 hrs	Circulatory overload Increase in preexisting asthma
Expectorants‡ (commonly used)	Saturated solution of KI (1.0 gm/ml)[10]	Oral	1.0–3.0 gm/24 hrs	Salivary adenitis, skin rashes, nausea, vomiting, cystitis, goiter
	Sodium iodide	Intravenous	1.0–2.0 gm/24 hrs	Same side-effects as oral iodide administration—not for prolonged use
	Glyceryl guaiacolate (Robitussin®[4]–100 mg/5 ml)	Oral	400–800 mg/24 hrs	Nausea, vomiting
	Ammonium chloride in cherry syrup (400 mg/5 ml)[10]	Oral	1.0–3.2 gm/24 hrs	Nausea, vomiting, acidosis
	Terpin hydrate (85 mg/5 ml)[10]	Oral	340–680 mg/24 hrs (1–2 tsp. q.i.d.)	Nausea, vomiting
	Common commercial expectorants[4] Dimetane® Benylin® Phenergan® Novahistine®	Oral	1–2 tsp. q.i.d.	Nausea, drowsiness, excitation, mouth dryness
Bronchodilators*	Ephedrine	Oral	25 mg q.i.d.	Nervousness, dry mouth, palpitations, urinary symptoms, constipation
	Theophylline	Oral Rectal (suppository or enema) Intravenous	130–250 mg q.i.d. 250–500 mg q 8 hrs p.r.n. 250–500 mg q 8 hrs p.r.n.	Nausea, vomiting, diarrhea, headache Same side-effects as oral administration, proctitis Same side-effects as oral administration, phlebitis
	Aqueous epinephrine 1:1000	Subcutaneous	0.2–0.4 ml q 4 hrs p.r.n.	Nausea, vomiting, palpitations, nervousness, tremor, hypertension
	Isoproterenol 1:200 (Isuprel®)	Aerosol Sublingual Intravenous	1–5 mg q 4 hrs p.r.n. 10–20 mg q 4 hrs p.r.n. 0.1–0.2 mg diluted in 5% D/W	Nausea, vomiting, palpitations, nervousness, tremor Same side-effects as aerosol administration Same side-effects as aerosol administration, hypotension
Mucolytic Agents*	N-acetylcysteine (Mucomyst®)	Nebulization Direct pulmonary instillation by catheter	1–4 ml of 10% solution 2–5 ml of 10% solution	Sulfur taste, cough, nausea, bronchospasm Same side-effects as aerosol administration
Wetting Agents‡ (detergents)	Alevaire® (Tyloxypal—0.125% $NaHCO_3$—2% Glycerin—5%)	Nebulization	5–10 ml treatment	No side-effects reported. Because product contains no preservative it must be used within 72 hrs after opening.
	Turgemist® (sodium ethasulfate—0.125% KI—0.1%)	Nebulization	2–5 ml treatment	No side-effects reported. Product contains no preservative.

* Expectorant efficacy documented.
† Expectorant efficacy accepted, some documentation.
‡ Expectorant efficacy doubted, no adequate documentation.

antibiotic. Usually the formation of mucus plugs can be prevented by placing the patient in a mist tent or by mask inhalation of a heated ultrasonically produced aerosol of water. Despite the color of the respiratory secretions, it is mostly mucus with abnormally increased viscosity. The color of these secretions is due to coarse but brittle bundles of deoxyribonucleic acid (DNA) from the nuclei of ruptured white blood cells. These bundles together with cells, bacteria, fibrin and plasma proteins are suspended in a matrix of the mucus. The action of bacterial enzymes on this mixture alters the basic light yellow color of the DNA to produce sputum which may have a color distinctive of a particular etiologic agent. The presence of bands of fibrin, as in all inflammatory exudates, also tends to solidify the secretions. When mucus is liquefied by the addition of large amounts of water or chemically dissolved with mucolytic agents, the DNA and fibrin provide relatively little resistance to flow and thereby to removal. For this reason, mucolytic agents such as N-acetylcysteine (Mucomyst®) have largely replaced deoxyribo-nuclease (Dornovac®) and trypsin (Tryptar®) (a fibrinolytic and mucolytic agent) as effective expectorant agents. Trypsin in particular has been shown to be excessively irritating to the respiratory tract epithelium.

In multilobar pneumonia or bronchopneumonia, administration of 2 to 4 ml of 10% or 20% N-acetylcysteine by intermittent positive pressure breathing apparatus four times daily or by a pump-driven nebulizer is effective in decreasing sputum viscosity.[2] It should be mentioned that N-acetylcysteine has some irritating properties, therefore, it should always be used with a small amount of a bronchodilator, such as 2 to 5 drops of 1:200 isoproterenol (Isuprel®), when being nebulized. Should the above therapy fail, the installation during bron-

choscopy of a mixture of 2.5 ml of 20% N-acetylcysteine and 2.5 ml warm saline followed by suction is effective.[3]

Laryngotracheobronchitis (croup). The mist tent, using ultrasonically nebulized warm water, is the treatment of choice in laryngotracheobronchitis, particularly in children. The efficacy of oral iodides in this condition has not been proven. The inhalation of 1.0 ml 20% N-acetylcysteine, 1.0 ml saline, and 6 to 8 drops of isoproterenol 1:200 nebulized through a DeVilbiss No. 40 or 42 nebulizer attached by plastic tubing to a DeVilbiss 501 pump four times daily is particularly useful when laryngotracheobronchitis occurs in patients with chronic bronchitis. One must be careful not to use rubber parts in the delivery apparatus when using N-acetylcysteine because this compound will dissolve rubber in the same manner it dissolves mucus.

Wetting agents (detergents), such as Alevaire®[4] or Turgemist® have been used extensively on the premise that lowering the surface tension of mucus will allow for its easy removal. However, controlled clinical studies show that Alevaire® does not lower sputum viscosity more than saline.[5] Turgemist® has not been subjected to controlled clinical trials in comparison with other drugs. A new drug, Ascoxal® (sodium percarbonate, ascorbic acid and copper sulfate), has been reported to significantly increase sputum volume upon nebulization.[6]

Bronchial Asthma. The combination of bronchodilators with expectorant measures is basic in the treatment of acute bronchial asthma. Ephedrine, 25 mg (adult dosage) every four hours, is the oral bronchodilator of choice in most instances. Theophylline and its derivatives are potent bronchodilators when administered by mouth, rectally, or parenterally; however, the repetitive administration of effective oral doses frequently result in nausea or vomiting.[7] Aqueous epinephrine 1:1000 in a dose of 0.2 to 0.4 ml (adult dosage), administered subcutaneously, is the parenteral bronchodilator of choice. Isoproterenol 1:200, 8 to 12 drops placed in 2.0 ml of saline, administered as an aerosol by a pump-driven nebulizer or IPPB apparatus, is an equally potent bronchodilator.

In acute bronchial asthma, oral iodides are best prescribed in the following manner: 10 drops of saturated solution of potassium iodide is taken in 4 oz of water. The dose is increased by 5 drops every four hours until the patient expectorates enough to feel relief. If on the following day the feeling of chest congestion recurs, the last effective dose of iodide is repeated. Upon relief, further iodide is unnecessary. The long-term use of daily oral iodides is accompanied by a high incidence of side-effects. During acute and severe episodes of asthma, 1 to 2 gm per day of sodium iodide can be given intravenously in a concentration of 1.0 gm per liter of fluid. The use of mist tents is not advised in acute bronchial asthma because absorption of water by the mucus results in swelling, thereby further decreasing the intrabronchial lumen.

Chronic bronchial asthma responds to the daily use of oral bronchodilators by allowing expectoration. The long-term use of oral iodides in adults is somewhat disappointing. However, children with chronic bronchial asthma require less steroid medication when given iodides over long periods of time.[8] The inhalation of isoproterenol 1:200, 5 to 8 drops in 2 ml saline twice a day delivered by a pump-powered nebulizer is useful in adults with chronic bronchospastic disease. This is particularly effective upon arising in the morning. The chronic or acute overuse of Freon-propelled bronchodilating aerosols is dangerous.

Acute Bronchitis. Oral iodides, when used as described for acute bronchial asthma, appear effective in facilitating expectoration in acute bronchitis. However, this effect has never been documented in a controlled situation. The use of other drugs such as glyceryl guaiacolate,[4,9] ammonium chloride,[10] iperac, terpin hydrate,[10] though popular with physicians and patients alike, have not yet been shown to be superior to the expectorant action of hot liquids or any other bitter-tasting concoction. Vapor from a "steamer" or a mist tent is comforting, if not effective in raising sputum.

In contrast to the other diseases discussed in this paper, acute bronchitis responds to the seemingly illogical combination of an expectorant and a cough suppressant. The cough associated with acute bronchitis is frequently nonproductive and irritating. A drug which facilitates expectoration relieves the feeling of "chest congestion." At night, however, the irritating and repetitive nature of the cough leads to loss of sleep and exhaustion. Therefore, a small nocturnal dose of codeine (5–10 mg) or hydrocodone (5 mg) (Tussonex® or Hycodan®) in a demulcent vehicle is of great benefit. Episodes of acute bronchitis are generally self-remitting so that the short-term use of cough suppressants does not result in mucus inspissation. The long-term use of cough suppressants in chronic lung disease is associated with many side-effects.

Chronic Obstructive Lung Disease. Patients with chronic obstructive lung disease (chronic bronchitis and emphysema) respond poorly, if at all, to expectorant therapy with oral drugs. Glyceryl guaiacolate, though frequently prescribed, has been recently found to be ineffective.[11] The long-term administration of iodides, the standard medication of the chest physician, are at last undergoing a double-blind and objective study in patients with chronic bronchitis in our laboratories. A new oral mucolytic drug, Bisolvon®, has been used extensively in Europe but has failed to have any effect on sputum viscosity in our clinical investigations. Perhaps, as has been suspected,[8] there is no effective oral drug which modifies pulmonary secretions for patients with this illness. Five to eight drops of isoproterenol 1:200 in 2.0 ml saline, nebulized by a pump or IPPB machine

2 to 3 times daily, is likely to provide the most tangible relief for the patient. The addition of 1.0 ml of 20% acetylcysteine to the above aerosol mixture is valuable when these patients become acutely ill.

Bronchiectasis. Postural drainage is still the mainstay of treatment for patients with bronchiectasis. New additions are the advent of chest clapping while the patient is in the semi-inverted position, as well as the inhalation of isoproterenol–saline–acetylcysteine aerosol just prior to the drainage.

Postoperative Atelectasis. Most postoperative atelectasis may be prevented by adequate hydration, turning in bed, forced coughing, and daily intermittent positive pressure breathing with saline nebulization. However, if atelectasis due to mucus plugging occurs, bronchoscopy with the insertion of 20% N-acetylcysteine and saline has been shown to be of benefit.[3]

Tracheostomies. Tracheotomy tubes may be readily cleared by the instillation of 2 to 3 ml of 10% acetylcysteine followed by non-traumatic suctioning using sterile technique.

Cystic Fibrosis. Outpatients with cystic fibrosis should sleep in a mist tent using ultrasonically nebulized water. Antibiotics may at times be added to the nebulizer. Long-term oral iodides are not indicated in these patients because they are highly susceptible to adverse gastroenterologic and dermatologic reactions. The patients appear to raise sputum much easier if they are given sodium bicarbonate 5 to 10 grains four times daily by mouth.

Bedrest. Patients confined to bed for long periods should receive IPPB with saline nebulization 1 to 2 times daily.

In summary, the purpose of expectorant measures are to remove excessive secretions from the chest. All expectorant measures may be classified as either modifying secretions within the lungs or actively removing them from the bronchi. The management of the common clinical situations in which inspissation of pulmonary secretions may occur was reviewed. It is necessary to employ specific expectorant drugs and procedures for each illness.

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Thorium-Induced Carcinoma of the Maxillary Sinus

G. L. SCHMITZ, MD, RICHARD PETERS, DDS, and R. H. LEHMAN, MD, Milwaukee, Wis: *Laryngoscope* 80:1722–1732 (Nov) 1970

The radioactive dye, thorium dioxide, has been used extensively in the past as a contrast medium. It was used both intravenously in dye studies of the liver and spleen and intracavitary to outline polypoid changes in the sinuses.

Thorium is the parent element of a naturally occurring radioactive family. It has a half life of 1.39×10^{10} years and most of the radiation is in the form of short range alpha particles. It is not excreted and remains in the body, retaining its radioactivity during the lifetime of the individual.

Several previous cases have been reported of squamous cell carcinomas of the maxillary sinus secondary to thorium instillation. A case is reported in which a carcinoma developed 15 years after instillation of thorium in a maxillary sinus. The long latency period exists, presumably because of the prolonged time for the radiation to reach a peak.

Because of the long latent period and the extensive use of thorium in the past, the finding of foreign bodies of metallic density in the sinuses should lead to a thorough investigation with removal of the foreign material and institution of proper therapy if an underlying neoplasm is present. □

Erythema Chronicum Migrans

R. J. SCRIMENTI, MD, Milwaukee, Wis: *Arch Derm* 102:104–105 (July) 1970

Our knowledge of this toxic, circinate skin eruption, occasionally associated with neurological symptoms comes primarily from European reports. The cause is uncertain, though spirochetes or rickettsiae have been incriminated. Arthropods act as vectors. A case is reported of chronic migrating erythema and radicular pain following a wood tick bite sustained in North Central Wisconsin. Laboratory studies were negative for specific organisms. Treatment with benzathine penicillin G was curative. To my knowledge, this is the first case in the United States. □

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President's Message to the House of Delegates

By George A. Behnke, MD, Kaukauna, Wisconsin

WHERE ARE WE GOING TODAY?

This is a reasonable question to ask. We are all aware of the rapid changes in the scientific practice of medicine, with new methods of therapy, new drugs, new surgical procedures and organ transplants. The changes in the socio-economic field of medicine are changing almost as rapidly as the scientific. It wasn't too many years ago that a President in his inaugural address said, "Ask not what your country can do for you, but what can you do for your country." He then turned around and gave us the biggest giveaway program we have ever known. Now today his family and his followers are continuing their great giveaway program. As a matter of fact, they are even trying to give away medicine.

If Kennedy were to succeed in passing his national health bill, the free enterprise practice of medicine would be gone. From every side we are bombarded with plans from various sources who are trying to tell us how we should practice medicine. The AMERIPLAN, sponsored by the American Hospital Association, would set the hospitals up as the health maintenance organizations. They would hire doctors; they would furnish medical care. The AMA's MEDICREDIT plan seeks to continue to provide private health insurance plans. It provides free choice of physicians. It preserves the doctor-patient relationship. Only for that segment who cannot afford to pay their own medical insurance would the government be involved in providing the funds by which private insurance could be purchased.

True, this is not a panacea for all the ills of provision of medical care, but it does maintain the free enterprise system practice of medicine, and keeps it out of the hands of the political bureaucracy.

In our own state of Wisconsin we face many of the same problems that are faced nationally in the provision of medical care and the other aspects of socio-economic medicine. Our greatest need in the state of Wisconsin, and incidentally, nationally, is to increase medical manpower. For many years the general public has accused the medical society of creating a doctor shortage. Nothing could be farther from the truth. I doubt that there is a physician in this room who would not welcome more physicians in the community to shorten his work week, to lighten his patient load, and thereby allowing him to practice the quality of medicine he would like to practice. The ever-increasing demands for medical care have lengthened our work week, have increased our patient load, and at times have made it difficult to practice quality medicine.

It is true that we have made some inroads into the problem of manpower shortage during the past year. Pressure has been brought to bear upon the medical schools to increase their student enrollment. Suggestions have been made in the revamping of curriculums, particularly to shorten the premedical years. It has been suggested that other facilities might be used in the preclinical years to train more physicians and take the load directly off the medical schools.

However, we have only dented the surface. We need to continue to exert friendly persuasion upon medical schools to increase their enrollment, to change their emphasis from research to the produc-

tion of clinical physicians, particularly of the primary practice type. It is true that research is important, and we certainly do not wish to discontinue this, but we do feel at the present time that a crash program is needed to produce primary physicians. It is also necessary to expand our internship and residency programs, particularly out into the state's community hospitals. There are many community hospitals in the state that are very well equipped, very well staffed, and which have well trained physicians for a training program for internships and residencies. National statistics have proven that only approximately 35% of medical students will stay within the state from which they graduate from medical school, but 60% of those who have had their postgraduate training, internship and residency, will remain within the state where they have taken this postgraduate training.

In the past year we have made some very definite inroads in establishing a better rapport between the State Legislature and the State Medical Society. For the first time the State Legislature has consulted the State Medical Society for leadership and guidance. As evidence of this, in the last few weeks there have been presented to the State Legislature three or four bills which are aimed at our primary problem of producing more medical manpower. These bills of various types are geared to increase medical school enrollment, increase loan funds to students, and stimulate an incentive for young doctors to stay in the state of Wisconsin. We need to continue our efforts to give leadership and guidance to the Legislature in all bills to increase medical manpower, whether it be medicine, nursing, physicians' assistants, or any allied medical fields.

In other legislative matters relating to medicine and delivery of health care, the State Medical Society has not fared well in the State Legislature. The recently passed bills on chiropractic payment for coverage under automobile insurance and Senate passage of chiropractic coverage under Workmen's Compensation will certainly lower the quality of care for many people.

I believe the time has come when we must sponsor legislation requiring chiropractic licensure to be dependent upon graduation from an approved school, accredited by the U. S. Office of Education or a recognized educational accrediting body.

I am firmly convinced that the time has come when we must establish a foundation or a similar mechanism to effectively deal with outside agencies who are continually putting pressure upon medicine and seeking to control medicine. We must have an effective agency for peer review, and if we do not establish this and maintain it, this function will be taken over by lay personnel and out of the hands of medicine.

It is imperative that we continue our leadership and guidance to the State Legislature in all matters pertaining to medicine.

We should and we must take a definite stand against the legalization of marijuana. It is only in recent years that we have convinced the public that alcoholism is a medical problem. Are we going to release our responsibility as far as marijuana is concerned to the sociologists and anthropologists, or are we going to recognize our responsibility and fight against its legalization in Wisconsin and in the nation?

I also think this State Society should affirm its approval of the AMA's June 1970 resolution on abortion.

During these troubled political times, it is imperative that we deal effectively with friends of medicine; and I challenge each of you to become politically involved. PACE has been an effective political arm and has contributed to "friends of medicine" regardless of party. Our support of PACE has been woefully weak. It behooves each and every member to get behind PACE with a voluntary contribution.

The number of late resolutions presented to the Council last evening brings to light what I consider a serious problem. I think it is unfair to you as delegates and to your component societies to have this many resolutions presented at the last minute. It doesn't allow you the right to study and discuss these matters with your own societies, so that you can properly represent their opinions. I strongly urge each of you to impress on your local societies the need to present any resolutions through the prescribed channels, so all societies may present their views.

Frequently I hear from physicians throughout the state of Wisconsin statements such as this: The State Medical Society isn't doing anything for me, or why don't people just let us alone and let us practice medicine. Well, to me this is like the paraphrase from the popular song—"to dream an impossible dream." To me, the physician who feels he doesn't need the State Medical Society or the physician who feels his only responsibility is to take care of patients is dreaming an impossible dream. Pressures from every turn are bearing down upon each of us as individuals and collectively as a state medical society.

Twenty years ago Wilbur Cohen presented a bill for socialized medicine. Maybe we haven't completely won the battle, but at least we still do not have socialized medicine today. Certainly, I would not blame any physician for dreaming the impossible dream or resorting to any method that he knows in his quest for this impossible dream.

The only possible way to reach our dream is for organized medicine to continue its fight against those forces which would destroy the free enterprise practice of medicine, and strive to provide quality medical care for all people.

Then we can ask:

Where are we going today? □

Parathyroid Hormone Measurements in Hyperparathyroidism and Hypercalcemia Due to Nonparathyroid Cancers

By Francis N. Lohrenz, MD, Marshfield, Wisconsin

PRIMARY HYPERPARATHYROIDISM still poses difficult problems in diagnosis, since it can present with biochemical criteria only.[1, 2] In this condition, autonomous hyperfunction of one or more glands leads to an excess of parathyroid hormone, causing hypercalcemia and changes in bone and other tissues. There may be an adenoma of one or more glands, hyperplasia of the chief cell variety, or of a clear cell type or, rarely, carcinoma. Meticulous dissection in the neck with identification of all parathyroid tissue is mandatory if cure is to be achieved.

Hypercalcemia associated with malignancy of nonparathyroid tissue is usually the result of metastases producing bony destruction.[3] Hypercalcemia in the absence of osseous metastases of parathyroid pathology was first reported by Gutman, Tyson, and Gutman.[4] Recently, Omenn, Roth, and Baker[5] reviewed in detail 73 cases of hyperparathyroidism associated with malignant tumors of nonparathyroid origin including nine previously unpublished cases.

From the Marshfield Clinic and Marshfield Clinic Foundation for Medical Research and Education.

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The assay for parathyroid hormone first described in 1963 has made possible further studies of parathyroid physiology in primary hyperparathyroidism and for evaluation of mechanisms of hypercalcemia production in malignancies.[6] Berson and Yalow[7] in 1967 reported elevated levels of parathyroid hormone assay in 15 of 29 patients with surgically confirmed hyperparathyroidism. Egdahl, Canterbury, and Reiss[8] found elevated parathyroid hormone levels preoperatively, with normal levels post-surgery, in nine patients with clinical and laboratory evidence of hyperparathyroidism. In nonparathyroid malignancies associated with hypercalcemia, antigenic material indistinguishable from parathyroid hormone has been demonstrated in tumor tissue of 15 patients.[5]

Over the past five years, through the courtesy of Doctors Rosalyn Yalow and Solomon Berson of the Bronx V. A. Hospital, New York, N. Y., hormone assays have been performed in nine patients with parathyroid adenomata and six patients with hypercalcemia due to malignancies. The serum calcium, phosphorus, and alkaline phosphatase were determined by standard laboratory methods with normal range as recorded. This report summarizes biochemical and clinical data on these patients.

TABLE 1—*Parathyroid hormone measurements in hyperparathyroidism before and after parathyroidectomy*

Patient No.	Sex	Age	Principal clinical features	Pathology	Size	Serum calcium (preop) mg 100 ml*	Serum calcium (postop) mg 100 ml*	Parathyroid hormone values (preop) μl-equiv ml†	Parathyroid hormone values (postop) μl-equiv ml†
1	F	68	Osteitis fibrosis cystica	Adenoma	3.5x4.5x8.2 cm	13.3	10.5	--	4
2	F	50	Urinary calculi	Adenoma	2.2x1.2x0.9 cm	12.1	10.2	4	4
3	F	47	Zollinger Ellison syndrome	Adenomata	1x0.8x0.5 cm and 2 gm lobulated second adenoma	11.4	9.7	15 16	6
4	F	50	Severe nausea	Adenoma	3x2x1.5 cm	17.2	10.2	--	2½ 3
5	F	40	Schizophrenia	Adenoma	2x2x1.2 cm	11.0	9.0	9	6
6	F	46	Urinary calculi	Adenoma	2x1x0.7 cm	11.1	10.2	2	0 2 7
7	F	59	Asymptomatic Hypercalcemia only	Adenoma	3.5x1.5x0.6 cm	11.8	9.4	45	0
8	F	63	Hypercalcemia only	Adenoma	2x1x0.5 cm	12.5	10.0	25	0
9	M	32	Zollinger-Ellison syndrome	Adenomata	1x5x3 cm and 1x1x1 cm	11.1	9.4	40	30

*Normals: 8.6–10.6 mg 100 ml

†Normals: Patient Nos. 1–4, 4–6 μl-equiv ml
Patient Nos. 5–9, 10–15 μl-equiv ml

TABLE 2—*Parathyroid hormone values in malignancy with hypercalcemia*

Patient No.	Sex	Age	Serum calcium (mg/100 ml)*	Serum phosphorus (mg/100 ml)*	Alkaline phosphatase (mg/100 ml)*	Blood urea nitrogen (mg/100 ml)*	Parathyroid hormone assay (μl-equiv/ml)†	Type of malignancy
1	F	73	16.5	4.5	...	72	6	Malignant lymphoma
2	M	66	12.9	4.6	...	49	4	Reticulum cell sarcoma
			← (48 hours later, after oral phosphate therapy) →					
			12.5	4.5		43	5	
3	F	69	7.6	3.7	8.8	22	6	Carcinoma of breast with bone metastasis, and hypocalcemia secondary to parathyroid removal
4	M	73	11.0	2.9	11.4	...	5.2 (day before nephrectomy)	Renal cell carcinoma
			11.6	1.7	12.6	...	6 (postoperative; day of surgery)	
			10.6	...	...	...	5.5 (postoperative; day after surgery)	
5	M	48	14.1	5.2	5.7	77	1.6	Carcinoma of stomach with osseous metastases
			← (several days later) →					
			11.8	4.9	6.0	67	1.8	
6	M	63	15.0	3.0	...	32	5	Malignant lymphoma
			← (after sodium phosphate intravenously) →					
			10.1	14.0	...	40	8	
			← (three days later) →					
			9.2	3.2	...	27	11	

*Normals: Serum calcium 8.6–10.6 mg/100 ml; serum phosphorus—2.5–4.0 mg/100 ml; alkaline phosphatase—2.9–11.1 KAU; blood urea nitrogen—10–20 mg/100 ml

†Normals: Patient Nos. 1–4, 4–6 μl-equiv/ml
Patient No. 5, 2–4 μl-equiv/ml
Patient No. 6, 10–15 μl-equiv/ml

Results. Table 1 lists our patients with hyperparathyroidism, presenting the principal clinical features, age, sex, pre- and postoperative serum calcium values, size of adenomata, and parathyroid hormone values. The diagnosis of hyperparathyroidism was suspected in nine adults from age 32 to 68, principally due to hypercalcemia verified on several occasions. Patient 1 presented with a pathological fracture of the right femur, and initially metastatic breast carcinoma was considered. A biopsy of the fracture area at the time of hip surgery was consistent with osteitis fibrosis cystica. A large parathyroid adenoma was removed at the same time.

Two patients had multiple endocrine adenomatosis, or a variant of the Zollinger–Ellison syndrome. Patient 2 had recurrent peptic ulcer symptoms relieved by 90% gastrectomy, but hypercalcemia persisted. Both serum calcium and parathyroid hormone measurements were within normal range after removal of a parathyroid adenoma. There has been no recurrence of clinical or biochemical endocrine disease after 18 months. Patient 9 had experienced a bilateral adrenalectomy for clinical and biochemical Cushing's syndrome. At the time of adrenalectomy, several pancreatic adenomata were removed and others remained. Hypercalcemia concomitant with a profound depression led to subsequent parathyroid surgery. He had normal calcium values subsequently, but there was no change in mental status. He died six months after parathyroid surgery of massive gastrointestinal hemorrhage, and is the subject of a previously published case report.[9] Unfortunately, post-mortem examination to verify further parathyroid adenomata or possibly nonparathyroid tissue producing parahormone-like peptides could not be accomplished.

Table 2 presents the age, sex, type of malignancy, and biochemical studies in six patients with various forms of malignancies producing hypercalcemia. Parathyroid hormone values were correlated with serum calcium, phosphorus and alkaline phosphatase in most patients. In none of this small group of patients was the serum parathyroid hormone value elevated beyond the range of normal—even when the level of serum calcium was changed with various modes of therapy. No tissue parathormone assay levels were done in this small group of patients. Four of the six are deceased. One patient, who had a nephrectomy for a renal cell carcinoma, still has moderate hypercalcemia. His parathyroid hormone levels were at the upper range of normal. No definite osseous metastases are evident thus far, after 18 months of follow-up. This type of malignancy is one of the more frequent which has been known to produce clinical and biochemical signs of hyperparathyroidism, and also immunochemical material consistent with parahormone.[5]

Summary. Nine patients who had surgery for parathyroid adenomata and six patients with hypercalcemia due to nonparathyroid malignancies are presented, with parathyroid hormone assays. In approximately one-half of the patients with hyperparathyroidism, the parahormone assays were elevated preoperatively and returned to normal limits

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after surgery. In this small group of patients having malignancies with hypercalcemia, none showed definite evidence of parathyroid hormone secretion into the serum.

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Hypersensitivity Pneumonitis Due to Contamination of an Air Conditioner

E. F. BANASZAK, MD, PhD; WALTER H. THIEDE, MD and JORDAN N. FINK, MD, Marquette School of Medicine, Milwaukee, Wis: *New Eng J Med* 283:271–276 (Aug 6) 1970

A type of hypersensitivity pneumonitis was suspected, studied and later confirmed in our group of 27 office workers, all of whom worked in the same office. Their symptoms consisted of chills, fever, malaise, cough and dyspnea occurring four to six hours after being in the office; the patients were free from symptoms on weekends or during vacation time.

The symptoms, x-ray findings, and pulmonary function studies aroused suspicion and, therefore, a search for the offending antigen was undertaken. The office under consideration was ventilated by a water-cooled and steam-heated air conditioner. Samples from the air conditioner, office dust, and other potentially contaminated sources were cultured at varying temperatures. From the cooling water a thermophilic actinomycete was cultured. Gel diffusion studies, with extracts of the organism, demonstrated precipitating antibodies in one symptomatic and eight asymptomatic patients. Insufflation of the antigen which was prepared from a saline extract of the fungal culture reproduced the clinical picture in one of the symptomatic patients. Four patients had positive rheumatoid factors which reverted to normal after avoiding exposure.

Pulmonary function abnormalities consisted of a restrictive ventilatory impairment, a low diffusing capacity for carbon monoxide and hypoxemia. Roentgenographic abnormalities varied according to the degree of exposure. Therapy consisted of avoidance of exposure. The heating system was replaced.

The study demonstrates another form of hypersensitivity pneumonitis similar to farmer's lung or bagassosis, but related only to a fungal antigen exposure. Another cause of false positive rheumatoid factor is demonstrated. □

Foreign-Body Perforation of the Intestinal Tract

MASSOUD MALEKI, MD, and WILLIAM E. EVANS, MD, The Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 101:475–477 (Oct) 1970

Doctors Massoud Maleki and William E. Evans, from the Department of Medicine of the Wisconsin College of Medicine in Milwaukee, published a paper entitled "Foreign-Body Perforation of the Intestinal Tract" in the October 1970 *Archives of Surgery*. They reported 12 cases, which were in addition to the approximately 282 cases previously recorded. Nine out of the 10 patients in whom information was available wore dentures. The relationship of dentures to foreign-body ingestion was regarded as significant by the authors.

In their 12 patients, the preoperative diagnoses ranged from right ovarian malignancy through peritonitis, perforated appendix, acute cholecystitis, and large-bowel obstruction. All 12 of their patients had a perforation of the bowel anywhere from the jejunum to the sigmoid colon. Only one patient revealed a history of foreign-body ingestion and in this case it was a hat pin. The other objects retrieved included toothpicks, both wooden and plastic, and chicken and fish bones. One patient, age 86, died on the eighth postoperative day; the other 11 patients all recovered.

The surgery varied from a simple closure up to a colostomy and, in four cases, small-bowel resection.

The authors concluded that consideration must be given to the rare event of foreign-body perforation of the intestinal tract and that nonmetallic objects such as toothpicks and small bones may undergo suppuration or digestion, which might explain the possibility in some cases of otherwise unexplained intestinal perforation. They noted that a history of ingestion of a foreign body is rarely available and that the relationship of foreign-body ingestion to the wearing of full dentures is clearly shown by their review. Treatment is determined by the level of perforation and the status of intestinal pathological patterns at the time of surgery.—VSF □

Anomalous Left Coronary Artery

By G. D. Friedman, MD, G. T. Hensley, MD
and J. E. Youker, MD, Milwaukee, Wisconsin

ANOMALIES OF THE CORONARY circulation are rare. Alexander, et al[1] reported an overall incidence of coronary anomalies of 2.85 per 1000 among 18,950 autopsies at Los Angeles County Hospital from 1940–49. Many different classifications of the various congenital anomalies of the coronary arteries have been proposed but all are based on one or more of the following vessel abnormalities: anomalous origin, fistulous communication, aneurysm formation, anomalous distribution, absence, stenosis or occlusion. From a clinical standpoint it is important only to make the determination as to whether the anomaly produces a physiologic disturbance, and if so, whether it is amenable to surgical correction. A most significant advancement in this area has dealt with the development of selective coronary arteriography. Through this diagnostic procedure pertinent information correlating physiologic changes with anatomic alterations can be ascertained and a more objective approach to surgical correction can be achieved.

This report deals with the rarely found anomaly of the left circumflex artery originating as a major branch of the right coronary, its clinical correlation, and demonstration by both cineangiography and necropsy dissection.

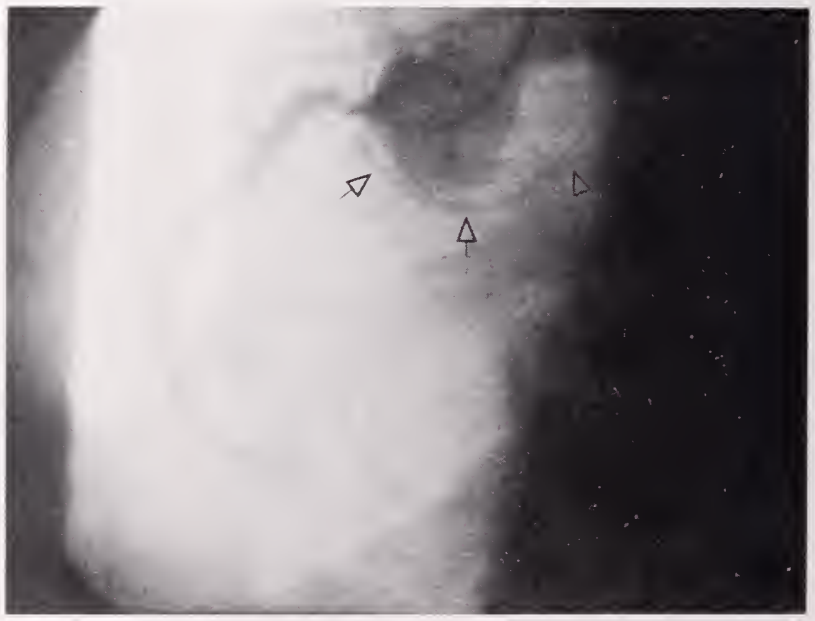
Case Report. A 43-year-old white man with a history of severe hypertension and angina had been the victim of four clinical myocardial infarctions in recent years and was becoming a cardiac cripple. The patient was admitted to the hospital for cardiac catheterization and cineangiography on April 8, 1969.

Coronary arteriography demonstrated diffuse atheromatous disease with a 50% narrowing in both major coronary arteries. Opacification of the right coronary artery (Fig 1) demonstrated a major sized branch originating from the right coronary vessel near its origin. This anomalous vessel passed to the left side of the heart and continued down over the lateral aspect of the left ventricle toward the apex. The most severe narrowing of the right coronary artery was in its midposterior portion at the origin of the acute marginal branch and also at the origin of the posterior descending branch. Opacification of the left coronary artery (Fig 2) demonstrated a modest sized left anterior descending and a large diagonal branch with most marked narrowing present at the bifurcation. These two vessels, along with the aforementioned anomalous circumflex branch, from the right coronary supply the left ventricle. No significant circumflex branch from the left coronary artery was demonstrated and hence the posterior aspect of the left ventricle appeared to be sparsely supplied with blood. A left ventricular ejection sequence did in fact demonstrate a weakened, delayed contraction of the posterior aspect of this chamber.

On May 13, 1969, the patient underwent a branched vein bypass from the ascending aorta to the anterior descending and major diagonal arteries. In addition, four internal mammary artery branches were implanted into the left ventricle, one anterior, one lateral, and two posterior. Postoperatively the patient's cardiac status improved markedly. He experienced diminished angina pectoris, and repeat cardiac catheterization with cineangiography demonstrated improved left posterior ventricular wall contraction. However, the patient developed serum hepatitis three months following his surgery. In spite of vigorous medical therapy, including three exchange transfusions, he died as the result of liver failure.

At autopsy the heart weighed 640 gm. The enlargement primarily involved the left ventricle with that myocardial wall measuring 1.3 to 1.6 mm in thickness. In the posterior wall of the left ventricle, two old scars measuring 1.5 to 2 cm in diameter were found. The left coronary originated normally from the left sinus of Valsalva and bifurcated after 3 cm

Fig. 1—Frame from cine arteriogram. Right coronary showing diffuse irregularity and narrowing at origin of acute marginal and posterior descending branches. Arrows indicate anomalous left circumflex artery.



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into an anterior descending and a larger major diagonal branch that supplied the anterior portion of the left ventricle. Careful scrutiny, however, revealed no left circumflex branch originating from any part of the left coronary. The right coronary originated from a double ostium in the right sinus of Valsalva. This rather large main right coronary followed a normal distribution in the right atrioventricular sulcus to terminate at the crus with a substantial posterior descending branch. A major branch, taking off from the double ostium, ran forward and to the left behind the pulmonary artery and into the left atrioventricular groove for a short distance (Fig 3). In the region of the obtuse angle it terminated by curving sharply down toward the apex of the heart as the left marginal artery, passing lateral to the diagonal branch. It is noteworthy that the anomalous artery followed the typical course in the left atrioventricular groove for only a relatively short distance rather than continuing around to the region of the posterior interventricular groove (shaded in Fig 4). Both right and left coronary arteries were affected by moderate diffuse atherosclerotic degeneration. Plaques protruded into the lumens, particularly in the proximal portions of both major arteries at the bifurcation of the left coronary artery branches, and at the posterior crus of the right coronary artery. These atheramatous narrowings created no more than a 50% reduction in cross-sectional diameter at any point. The branched vein bypass graft and the most anterior of the four internal mammary implants were removed intact with the heart and appeared completely patent. A radiopaque gelatin injection mass infused into the vein graft filled the coronary system and was found to "bleed" from the cut ends of the internal mammary implants, thus demonstrating anatomic patency.

Discussion. In 1933, Anatopol[2] was the first to describe this unusual anomaly. He reported three cases of the left circumflex artery arising from the right coronary ostium and one case of the left circumflex originating as a branch of the right coronary. In all four of these cases, the circumflex artery followed a normal course in the left atrioventricular sulcus to the posterior interven-

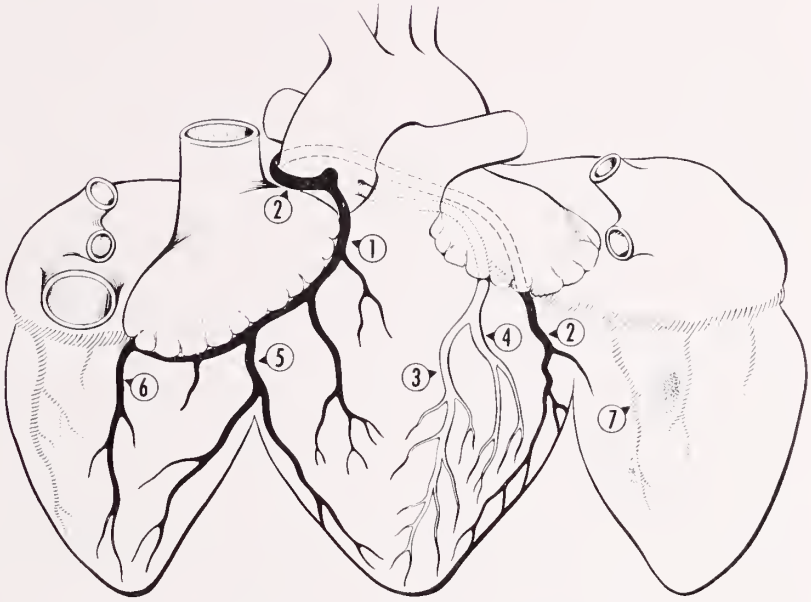


Fig. 4—Further dissection of heart. Anterior and right aspects in center. Left posterior, picture right; right posterior, picture left. (1) to (4) As in Figure 3. (5) Artery of acute angle. (6) Posterior interventricular sulcal branch of right. (7) Shaded vessel is expected course of absent posterior circumflex artery. Two stippled patches are sites of fibrous scars.

Fig. 2—As in Figure 1. Left coronary in left anterior oblique projection. Single open arrow indicates 50% narrowing at the bifurcation into anterior descending (solid arrow) and diagonal (double open arrows) branches. No circumflex vessel demonstrated. Some irregularity and narrowing of anterior descending branch.

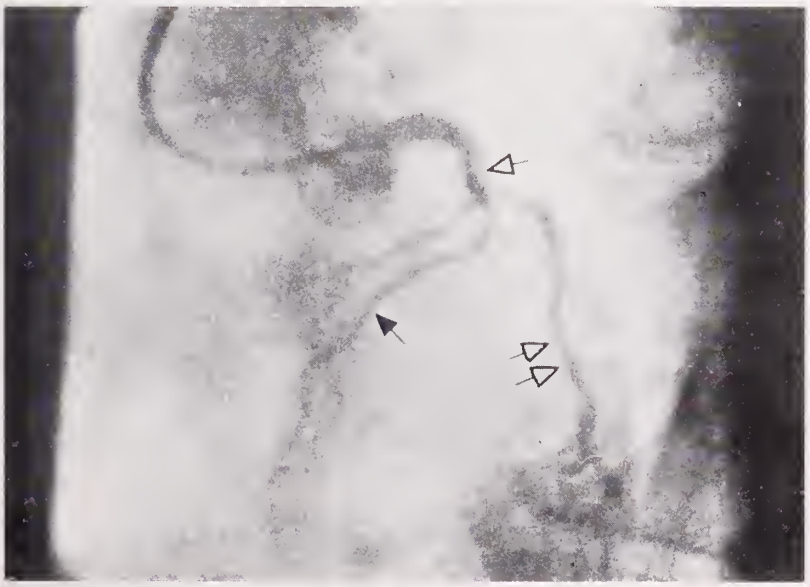
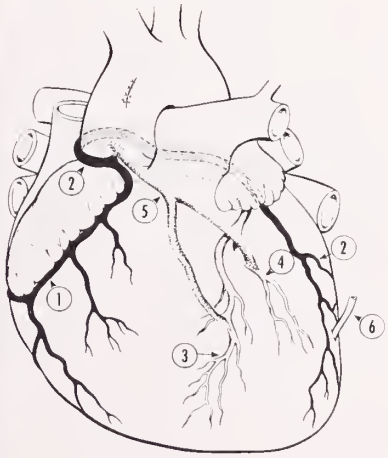


Fig. 3—Anatomy of coronary vessels established at autopsy. (1) Right coronary artery. (2) Anomalous left circumflex, a branch of right artery. (3) and (4) Terminal branches of anterior descending artery. (5) Branched vein graft. (6) Internal mammary implant.



tricular groove. In the retrospective study by Alexander and Griffith,[1] among 18,950 consecutive autopsies, there were four cases noted in which the left circumflex artery took origin from a separate ostium in the right sinus of Valsalva and four cases in which the circumflex came off the right coronary as a separate branch. James[3] performed meticulous postmortem examinations on 106 hearts and found one in which the left circumflex originated as a branch of the right coronary, looped behind the aorta and into the left atrioventricular sulcus and continued in the distribution of the left circumflex. Dadswell[4] similarly reported a single case of this anomaly. Demany and Zimmerman[5] reported a case demonstrated by cineangiography in which the left circumflex branched from the right coronary, although the latter originated in the left sinus of Valsalva. James[3] found that in 81% of the 106 hearts he studied, the left circumflex terminated some variable distance before reaching the crus by leaving the atrioventricular sulcus and descending toward the apex of the left ventricle. The termination actually occurred nearest the margo obtusis in 20% of the cases.

In the case described here, it is recalled that the anomalous left circumflex coursed but a very short distance in the atrioventricular sulcus before directing itself downward near the obtuse margin and toward the apex. This is particularly significant in that there were no other major vessels that compensated for this "early" termination of the circumflex, and the posterior wall of the left ventricle was left without a blood supply adequate for the hypertrophic myocardial mass. This was confirmed by the cineangiography study demonstrating weakened, delayed left posterior wall contractions as well as a paucity of arterial vasculature supplying this area. At autopsy it is recalled that the two major infarcts were found in the posterior wall of the left ventricle. It is likewise noteworthy that following the revascularization procedure, a marked improvement in left ventricular wall contraction resulted.

Summary. A case of anomalous origin of the left circumflex artery with associated deficiency of arterial supply of the posterior left ventricle is reported and compared with 15 cases found in the literature in which anomalous origin was found. This is a rare developmental variation which is not usually symptomatic. In this case symptoms of coronary insufficiency became manifest in adult life when the heart was hypertrophic and there was moderate atherosclerosis of the coronary arteries. It is possible to recognize the anomaly during life by means of selective coronary arteriography.

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Primary Cutaneous Inoculation Tuberculosis

MICHAEL W. RYTEL, MD; EUGENE S. DAVIS, MD, and KENNETH J. PREBIL, MD, Department of Medicine, Section of Infectious Diseases, Marquette School of Medicine, Milwaukee, Wis: *Amer Rev Resp Dis* 102: 264–267 (Aug) 1970

Inoculation tuberculosis is a rare disease that constitutes an occupational hazard for physicians, especially pathologists. At least 16 cases involving medical or paramedical personnel have been reported in the world literature. The present report describes 2 additional cases of inoculation tuberculosis in medical students, prosectors in the Department of Pathology at the University of Tennessee College of Medicine, who contracted their infection while performing autopsies on patients with disseminated tuberculosis.

It is of interest that in both of these patients, the lesions occurred in areas of the hands subjected to constant, minor trauma, but neither case was associated with laceration or any obvious lapse in autopsy technique. The initial diagnosis in both cases was that of a pyogenic ulcer, and only after the patients' lesions did not respond to topical therapy were steps initiated that led to the correct diagnosis.

Two different modes of therapy were used in our patients. One consisted of biopsy excision of the lesion combined with chemotherapy with isoniazid and PAS; in the other, the drugs were used alone. Although ultimate results were equally satisfactory, the combined surgical–medical therapy resulted in more rapid healing of the skin lesion and decrudescence of lymphadenopathy. □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Professor of Clinical Pharmacology, Medical College of Wisconsin, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Management of Postoperative Problems

By Daniel M. Philbin, MD and Richard I. H. Wang PhD, MD, Milwaukee, Wisconsin

KNOWLEDGE OF THE PROBLEMS which may arise following surgery is not only important to the surgeons and anesthesiologists but also to the internists and the family physicians. Frequently, an unexpected emergency occurs and any physician may be called upon to manage the patient. To avoid catastrophe, the sudden manifestation of postoperative complications demands rapid but accurate diagnosis and treatment. Because there is usually very little time, if any, for the physician to consult with the literature, the necessity of a readily available reference to help cope with this urgent situation is indeed justified. The purpose of this review is to present a rational approach in the management of postoperative problems.

Postoperative problems generally fall into three major categories: respiratory, circulatory, and neurological. For clarity of presentation, the management of each is described individually under the following headings:

I. Respiratory Problems

A. HYPOVENTILATION

1. *Airway obstruction.* The development of a partial or complete airway obstruction, which is extremely common, should be readily recognized. Treatment is usually accomplished by simply elevating the mandible in a snoring patient. An oropharyngeal or nasal airway may occasionally be necessary. In the presence of regurgitation, the dislodged food particles can be removed by applying proper suction. Airway obstruction may result from the presence of a mucous plug in an endotracheal or tracheostomy tube. This can be readily remedied by passing a sterile catheter so as to assure patency.

2. *Chest restriction.* Restrictive surgical binders either on the chest or on the abdomen, while not in common usage, may sometimes be so tight that they limit the patient's respiratory excursions. This could be readily resolved by reapplying the binders suitably.

3. *Physiologic and pharmacologic causes.* Hypoventilation of minor degree usually leads to uneventful recovery without treatment. However, in the presence of severe hypoventilation definitive diagnosis and treatment are needed in order to avoid impending cerebral and cardiovascular disaster. The possible causes of hypoventilation in a postoperative patient can be due to a number of factors such as the type and amount of pre-anesthetic medications, the underlying physical condition of the patient, the length and extensiveness of the operative procedure, the nature and techniques of anesthesia, and all the administered drugs. Heavy premedications with narcotics and/or barbiturates to an elderly subject may result in postoperative hypoventilation following a brief operative procedure. To rule out the possibility of narcotic overdose, a test dose of either 2 mg of nalorphine (Nalline®) or 0.5 mg of levallorphan (Lorfan®) should be given parenterally. If the ventilation improves, further doses can be given as indicated. If hypoventilation becomes worse, further use of a narcotic antagonist is not justified, because a narcotic antagonist has a respiratory depressant property *per se.* Since there is no reliable antagonistic drug for barbiturate overdose, conservative treatment by assisting the patient's respiration via ventilator is recommended.

The nature of the operative procedure may be a contributing factor to postsurgical hypoventilation. For example, it is painful to expand the chest wall due to a thoracotomy incision. So the patient invariably prevents this painful process by reducing the tidal volumes. The remedy for this condition is to provide adequate analgesia through the judicious use of either potent narcotic analgesics or local anesthetics. Likewise a high abdominal incision, particularly in the right upper quadrant, may result in postsurgical hypoventilation.

One of the important physiologic causes of postoperative hypoventilation is anesthetic technique.

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The use of prolonged hyperventilation during anesthesia results in a carbon dioxide washout from the body stores. This in turn necessitates a compensatory period of hypoventilation. To avoid the development of hypoxia, supplemental oxygen can be administered in the patient's inspired air. When fat soluble inhalation anesthetics such as ether and methoxyflurane (Penthrane®) are used, the recovery period is prolonged. In the post anesthetic period the tidal volumes are frequently less than satisfactory.

All the drugs administered to the patient throughout the operative period should be considered when hypoventilation is present. The use of a balanced anesthesia technique with a large amount of narcotic analgesics, barbiturates, and muscle relaxants is a cogent source of respiratory depression. Peripheral nerve stimulation and the test dose of a narcotic antagonist (as described above) will determine if muscle relaxants and narcotic analgesics are responsible for the respiratory depression. If the tests are positive, therapeutic doses of narcotic antagonists (such as 5 mg of nalorphine or 1 mg of levallorphan) and 1 mg of atropine plus 2 to 3 mg of neostigmine intravenously are indicated to reverse the effects of narcotic analgesics and muscle relaxants. If adequate reversal cannot be achieved, one can always resort to conservative treatment by ventilating the patient until the depressant effects have subsided.

The effects of other drugs, received by the patient, occasionally may be responsible for ventilatory problems. For example, the potentiation of curare by the concomitant use of certain antibiotics such as neomycin will prolong the period of muscle relaxation.

B. Apnea

Prolonged postoperative apnea may result from any of the foregoing causes. In addition, several other factors should be considered. Occasionally a patient with pseudocholinesterase deficiency will exhibit prolonged periods of apnea following a single injection of succinylcholine. Likewise it is also important to keep in mind that the concomitant use of anticholinesterase drugs such as diisopropyl fluorophosphate along with succinylcholine as muscle relaxant will result in prolonged apnea.

The only treatment is mechanical assistance until an adequate ventilatory pattern returns. This may be a few or even many hours.

Apnea may be the resultant from a neurological disaster. This is described later in the text.

II. Circulatory Problems

A. Tachycardia

Persistent tachycardia in a postoperative patient is indicative of hypovolemia until proven otherwise. Intra- and postoperative bleeding are the most common causes; therefore, adequate replacement therapy is essential, and the patient should be examined for active bleeding. The other important causes of tachycardia are secondary to pain and/or carbon dioxide retention. Narcotic analgesics can be used to allay pain and mechanical assistance to remove excess carbon dioxide retention.

When the above mentioned causes are ruled out and yet tachycardia persists, it is advisable to ascertain the type of tachycardia by electrocardiographic (ECG) studies. Tachycardia can result from the occurrence of a coronary occlusion or myocardial ischemia during anesthesia. In this case the tachycardia is subsequent to impending myocardial failure. Serial ECG studies and a serum glutamic oxaloacetic transaminase (SGOT) test should be ordered to follow the course of the patient postoperatively.

B. Hypotension

Hypotension is frequently due to hypovolemia. Diagnosis of inadequate replacement of blood loss may be aided by a compensatory tachycardia, a low or falling central venous pressure or hematocrit and a poor urinary output. The treatment of uncomplicated hypovolemic hypotension is adequate replacement. The danger of a prolonged period of hypotension may lead to tissue hypoxia and metabolic acidosis which in turn may result in irreversible shock.

Occasionally hypotension is the result of myocardial ischemia or infarction following an acute episode of coronary occlusion. Adequate therapy with digitalis for heart failure, vasopressors and alphaadrenergic blocker such as phenoxybenzamine hydrochloride (Dibenzyline®) for proper vascular tone, and corticosteroids for adrenal insufficiency should be appropriately administered as indicated.

If the patient is being mechanically ventilated, particularly if continuous positive pressure (CPPB) is being applied, hypotension may be a reflection of the decreased cardiac output secondary to diminished venous return. Adjustment of the respirator will usually suffice, although in some instances the use of CPPB may have to be abandoned, at least temporarily.

C. Hypertension

Postoperative patients may occasionally show mild elevations in their systolic blood pressure. This is usually a reflection of pain which can be readily remedied by providing appropriate analgesia. Occasionally hypertension is an autonomic response to hypoventilation and carbon dioxide retention which can be easily eliminated by adequate ventilation. However, failure of blood pressure returning to the patient's normal range after the corrective treatment should raise the suspicion of a central nervous system cause. A neurologic examination is indicated for ascertaining a specific diagnosis and treatment.

When the anesthetic administered has consisted primarily of intravenous morphine, the first few postanesthetic hours may see marked rise in blood pres-

sure, probably due to release of catecholamine from the adrenal gland. The use of chlorpromazine (Thorazine®) 5 to 15 mg intravenously is usually sufficient to restore normal values. On occasion, trimethaphan (Arfonad®) in a slow intravenous drip may be required for only a very short time.

D. Arrhythmias

Brief periods of arrhythmias may be anticipated during periods of hypoxia and hypercarbia and will disappear after instituting adequate ventilation. For other causes of arrhythmias, electrocardiographic and serum electrolyte studies should be ordered. The patient's history and current clinical studies should be reviewed for evidence of coronary and myocardial pathology. The consumption of certain types of drugs such as digitalis, quinidine, diuretics, or thyroid medications should be scrutinized. The loss of gastrointestinal secretions should be replaced and the possibility of electrolyte imbalance should be appropriately corrected.

The use of intravenous lidocaine (Xylocaine®), diphenylhydantoin (Dilantin®), propranolol (Inderal®), and bretylium tosylate should be considered in the treatment of persistent arrhythmias; but the details of their indications, dosages, and toxicities are beyond the scope of this presentation.

III. Neurological Problems

A. Convulsions

The occurrence of postoperative convulsions is fortunately extremely rare today. Seizures secondary to hypoxia or hypercarbia are almost non-existent. Grand mal seizures may appear in hypersensitive patients receiving local anesthetics and other central nervous system stimulants. Occasionally seizures are due to overdoses of such medications in a non-allergic individual, such as the inadvertent entrance of local anesthetics intravenously. It is important to be alert when administering such drugs to a patient with a history of epilepsy.

A cerebral vascular accident, either hemorrhage, embolism or thrombosis, may produce convulsions postoperatively. Treatment will depend upon the neurological diagnosis and the condition of the patient.

A rare incidence of hyperpyrexia may be responsible for a generalized convulsion. The importance of early recognition and prompt management of the elevated temperature as well as profound metabolism acidosis cannot be overemphasized.

B. Prolonged Unconsciousness

Failure of the patient to begin responding in a relatively short or an expected period following a general anesthetic is always an alarming event. Sometimes the status of the patient is not easily assessed and the diagnosis is a perplexing problem. The possible causes of prolonged unconsciousness are overdose of anesthetics and other depressant drugs, prolonged hypoxia during surgery, extended periods of hypotension or shock, cerebrovascular accident of various etiologies, hypoglycemic shock, severe acidosis, hypothermia especially in children, and so forth. Appropriate treatment should be vigorously instituted when definitive diagnosis is made. However, general approach of employing a conservative management of the unconscious patient must be carried out by providing oxygen, adequate ventilation, fluid, electrolyte and blood replacement, and proper temperature so as to maintain the vital signs at a satisfactory level. □

Repair of Cicatricial Entropion of Upper Eyelids

R. K. DORTZBACH, MD, University Hospitals, Madison, Wis: *Arch Ophthal* 85:82–89 (Jan) 1971

Cicatricial entropion of the upper eyelid can cause severe damage to the cornea and loss of vision. Standard techniques sometimes fail to repair the deformity, or they are not suited to the type of defect needing correction. Four procedures are described to correct different forms of cicatricial entropion of the upper eyelid.

(1) Chronic cicatricial entropion associated with trichiasis can best be corrected by splitting the upper eyelid in the grey line, sliding the anterior lamina upwards, and placing a buccal mucosa graft on the lower anterior surface of the tarsus.

(2) When the cicatricial entropion involves only the eyelid margin, a modification of the Hotz technique is used. A horizontal incision is made at the lid fold through the skin and orbicularis muscles; a row of sutures is then placed through the skin edges and tarsus so as to use the skin below the incision to put traction on the eyelid margin and pull it forward.

(3) The third form of cicatricial entropion, "window-shade entropion," occurs after the tarsus has been excised. Because of loss of rigidity, the eyelid rolls up like a window-shade. Correction is achieved by splitting the lid and inserting a piece of collagen film to provide both rigidity and appropriate anterior traction on the lid margin.

(4) Cicatricial entropion is likely to occur after levator resection for ptosis when the conjunctival approach is used as a second attempt at ptosis repair. The correction of this type of problem is often quite complicated, and one case is used to describe how such a repair can be accomplished. Techniques used were excision of cicatricial tissue, buccal mucosa grafts in the superior fornix, and utilization of the eyelid structures anterior to the tarsus for traction on the eyelid margin. □

Diagnostic Enzymology in Myocardial Infarction and Acute Chest Pain

THEODORE ROWAN, MD, Beaver Dam, Wis.: *Guy's Hospital Reports* 119:221–233 (No. 3) 1970

Enzyme determinations are now generally accepted as a useful diagnostic tool. The study of enzymes in relation to disease has expanded considerably in the last decade, and the clinical laboratory is able to provide information concerning many disease processes associated with tissue damage or destruction.

Of recent interest and importance has been the expansion of diagnostically usable enzyme determinations in patients with heart disease or chest pain of varying aetiology, principally in myocardial infarction.

This present study was undertaken to determine the most practicable and informative combination of enzyme tests or 'panel' that could be used in individuals with heart disease, taking into consideration time and cost. The tests considered to be of most use, and utilized in this study, were serum glutamic oxalo-acetic transaminase (SGOT), creatine phosphokinase (CPK), serum alpha hydroxybutyrate dehydrogenase (SHBD), and lactic dehydrogenase and its isoenzymes (LDH and isozymes).

After the initial study a suitable 'panel' was developed which excluded the SHBD, and a larger series was evaluated using it.

Multiple and often sequential enzyme tests are needed to evaluate a particular problem and failure to do these may hinder rather than help in making a diagnosis. To use intelligently *several* enzyme determinations in a number of patients is just as important as a good history. SGOT and more recently CPK determinations have become standard enzyme determinations in confirming a diagnosis of myocardial infarction and in estimating damaged tissue and prognosis. Any additional information that can be obtained in difficult diagnostic presentations, complications of existing disease processes or postoperative states for better evaluation of prognosis is desirable.

A modified 'cardiac' enzyme panel is recommended (Table 1) for investigation of chest pain. This group of tests is recommended for their combined sensitivity, specificity, exposure of possible iatrogenic alterations, and prognostic implications. A straight-forward example of myocardial infarction may be simply confirmed by an SGOT or CPK determination on 3 successive days, but even in these cases congestive heart failure might supervene and might go undetected for a period of time. LDH isozymes may indicate this and influence the physician's therapy. Isozymes can be usefully run for 7 to 10 days or longer while there is evidence of active heart disease or failure. It should be remembered that haemolysis of any origin will significantly affect LDH and SHBD results, but will not change a CPK value.

TABLE 1—*Suggested 'Cardiac' Enzyme Panel*

	Day 1	Day 2	Day 3	Days 7–10
SGOT	+	+	+	--------
CPK	+	+	+	--------
LDH Total	+	+	--------	+
LDH Isozymes	--------	+	--------	+

The LDH inhibition ratio is a good alternative to LDH isozymes by electrophoresis, if the latter is not available; both are considered superior to LDH isozymes by heat fractionation. The SHBD/LDH ratio is considered of little value. The SHBD as a single test is helpful, but if more than one test is employed, as suggested, it may be eliminated.

The question of cost always has to be considered, as well as availability and desirability, though considerations of patient care must come first. Where there is any question about the cause of acute chest pain, or of the course or prognosis in myocardial infarction, the suggested 'cardiac' enzyme panel may be helpful. □

Long-Term Integrity of Renal Function in Cadaver Allografts

WELDON D. SHELP, MD, FRITZ H. BACH, MD, WILLIAM A. KISKEN, MD, MARGARET NEWTON, MD, RICHARD E. RIESELBACH, MD, and ARVIN B. WEINSTEIN, MD, University of Wisconsin Medical School, Madison, Wis: *JAMA* 213:1443–1447 (Aug 31) 1970

In general, renal transplant recipients of cadaver kidneys fare less well than recipients of living related donor kidneys in regard to incidence of rejection episodes and stability of renal function. Specific renal function measurements of four cadaver recipients surviving a mean of 29 months without experiencing rejection are compared with those of seven well-matched living related donor recipients who have maintained optimal stability of renal function a minimum of one year following transplant. Renal function of the cadaver group compared favorably and in certain instances exceeded that of the living donor group. These data indicate that even without histocompatibility testing, transplantation of cadaver kidneys can occasionally result in a sustained preservation of renal function which closely parallels that seen in well-matched recipients. Excluding chance histocompatibility, the factors related to such therapeutic success are unknown. □

NEW DRUG RESEARCH: Droperidol

Droperidol: Provided good sedation in a significantly larger proportion of pre-surgery patients than did secobarbital or placebo. By Dr. C. R. Stephen, Parkland Memorial Hospital, Dallas, Texas.—AMERICAN DRUGGIST, October 19, 1970 □

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Management of High-risk Pregnancies Utilizing a Rapid Estriol Determination

By L. B. Curet, MD, I. H. Carlson, MD, and H. F. Farb, MD
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THE ELUCIDATION, by Diczfaluzi and others,[1] of the interrelation between the fetus and the placenta in the production of estriol has provided us with a means of assessing placental function. It is now known that from maternal precursors (acetate and cholesterol) which undergo conversion to pregnenolone in the placenta, the fetal adrenals produce androgenic steroids which after hydroxylation by the fetal liver are converted to estriol by the placenta. The estriol thus produced is conjugated by the maternal liver and is excreted in the urine as estriol glucosiduronate. Thus by measuring the 24-hour urinary excretion of estriol by the mother we can gather an idea of how well the fetal–placental unit is functioning. At the University of Wisconsin Medical Center in Madison we have evaluated three rapid means of measuring urinary estriol and have found that the enzymatic hydrolysis followed by gas chromatography of the sample offers the most reliable measurement.[2] This report presents some of our results utilizing the gas chromatographic measurement of estriol for assessing placental function.

Methods. Sixteen patients attending our High-risk Pregnancy Clinic were followed. They collected 24-hour urinary samples every week from the 30th week until delivery. Eight patients were diabetic, seven had toxemia, chronic hypertensive or renal disease, and one patient had rupture of the membranes at 31 weeks. Six normal pregnant patients were asked to collect urine specimens on an identical schedule, and the values obtained served as controls. The urine specimens were refrigerated (no preservative necessary) during the collection period, and as soon as the 24-hour period was over they were brought to the laboratory where analyses were performed within one to three days.

Results and Discussion. Normal values are presented in Figure 1. In no patient was the urinary excretion of estriol less than 10 mg/24 hours. Although there was some variation in individual

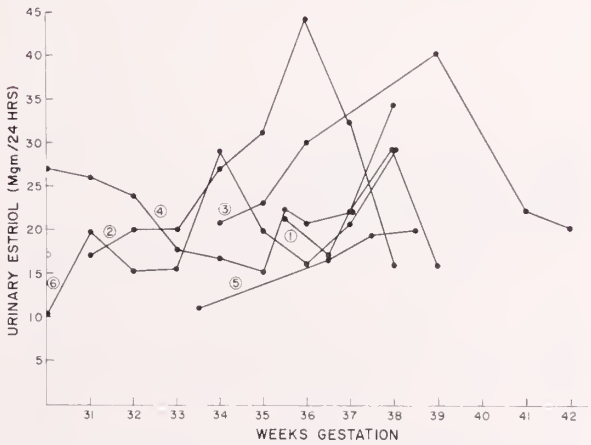

Fig. 1—Urinary estriol excretion during pregnancy in the normal control group.

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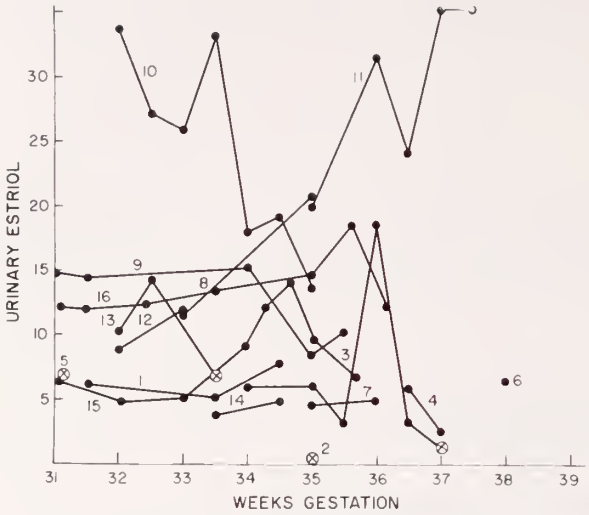

Fig. 2—Urinary estriol excretion during pregnancy in the complicated group.

levels for each patient, the trend was for a gradual increase in all patients as pregnancy progressed. In three patients the urinary excretion of estriol began to fall about two to three weeks prior to delivery; however, the lower value seen was above 15 mg/24 hours in all three cases.

Estriol excretion in the patients with complicated pregnancies is presented in Figure 2 and Table 1. Except for patients 8, 10 and 11 all values were consistently below 15 mg/24 hours. Furthermore, individual values tended to either remain at the same level or go down. Only patient 11 showed a trend to higher values as gestation proceeded.

Based on these data we now follow all high-risk pregnancies with serial measurements of estriol excretion. If the values are consistently above 10 mg/24 hours and show an upward swing, we allow patients to go to term. If values are less than 10 mg/24 hours but stable, we deliver the patient at 37 to 38 weeks.

Any time, after 33 weeks, if estriol excretion shows a persistent tendency to go down, we interrupt the pregnancy. At least two successive determinations must demonstrate the declining trend. Naturally the lower the original values are the prompter we act if there is a drop in estriol, as the lower the estriol excretion the more compromised the fetus is initially.

TABLE 1—*Diagnosis and outcome of high-risk pregnancy group*

Patient	Problem	Baby
1	Small abruptio	
	Premature rupture B.O.W.—31 weeks	Alive—Apgar 7
2	Diabetic	Dead fetus
3	Chronic renal disease and toxemia	Dead fetus
4	Severe toxemia	Alive—Apgar 8
5	Chronic hypertension and renal disease	Dead fetus
6	Diabetic and hypertension	Alive—Apgar 10
7	Hypertension	Alive—Apgar 9
8	Preeclampsia	Alive—Apgar 7
9	Chronic renal disease and preeclampsia	Alive—Apgar 9
10	Preeclampsia	Alive—Apgar 2
11	Diabetic	Alive—Apgar 9
12	Diabetic	Alive—Apgar 1
13	Diabetic and toxemia	Dead fetus
14	Diabetic	Alive—Apgar 9
15	Diabetic	Alive—Apgar 1
16	Diabetic	Alive—Apgar 1

In our hands we find that estriol determination in the urine offers reliable and useful information for the proper management of the high-risk pregnancy. However, we realize that estriol measurement alone is not the answer to complete placental evaluation, and we are currently evaluating the reliability of serum levels of heat stable alkaline phosphatase, plasma levels of placental lactogen and ultrasonic measurement of the fetal biparietal diameter as additional indexes of placental function and fetal well being. Lastly we do not use these tests as substitutes for good clinical sense but only as a valuable adjunct to clinical evaluation.

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Clinical and Physiological Evaluation of Mucolytic Agents Nebulized with Isoproterenol

S. R. HIRSCH, MD, P. F. VIERNES, MD and R. C. KORY, MD, Veterans Administration Hospital, Wood, Wis: *Thorax* 25:737–743 (Nov) 1970

In a controlled five-week cross-over study in 12 patients with chronic bronchitis, the effects of nebulized 10% N-acetylcysteine plus isoproterenol were compared with a new drug, sodium 2-mercaptoethane sulphonate, in 10% concentration also nebulized with isoproterenol. Both combinations were compared with a control aerosol of saline and a second control aerosol of saline plus isoproterenol. Both 10% 2-mercaptoethane sulphonate and 10% N-acetylcysteine were highly effective in thinning mucoid, mucopurulent or purulent sputum. Subjective improvement in these patients, however, was related to the isoproterenol rather than to the mucolytic agents. When nebulized with isoproterenol, neither mucolytic agent was associated with bronchospasm in any patient. Physical findings, spirometric values, and sputum volume were unaffected by these mucolytic agents. □

Nocturnal Functional Bladder Capacity in Enuretic Children

By Charles W. Troup, MD and Norman B. Hodgson, MD
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DR. CHARLES W. TROUP presented the winning resident-intern paper at the Annual Meeting of the State Medical Society of Wisconsin, May 14, 1970, in Milwaukee. He was given $100 as the William S. Middleton Award.

IN THE EARLY 1950s several articles appeared in the pediatric literature[1,2] advancing the thesis that enuretic children excrete an abnormally large nocturnal volume, concluding that enuresis is commonly due to anomalous renal secretion at night. However, other studies performed during that same period have tended to disprove this theory of nocturnal polyuria in enuretics and substantiate that there is a 2:1 ratio of daytime urinary volume as compared to nocturnal volume both in enuretics and nonenuretics.[3,4] Muellner[5] inferred from his data obtained in studying 30 children that the enuretic child has a much smaller than normal total bladder capacity and in effect retains the bladder capacity of a two-year-old which is much too small to hold the entire output of night urine of a child aged 4½ years or older.

The work of Starfield[6] reiterates this theory by stating that if output exceeds the functional retentive capacity of the bladder (whatever that might be) the child either will wake to void or will wet his bed. The cystometric studies by Linderholm[7] clearly document that enuretic children have functionally smaller bladder capacities, most likely on the basis of an uninhibited reflex neurogenic detrussor response. Other recent investigators also conclude that, as a group, enuretic children have functionally smaller bladder capacities when compared to similar nonenuretic children.[8]

To our knowledge there are no published reports, to date, that have specifically measured the true functional nocturnal urinary volumes in enuretics, recording the volume of urine voided at the precise time that these children wet the bed. This study was undertaken to determine if there is a diurnal–nocturnal difference in the functional bladder capacity of enuretic children and to compare this group with a control group of nonenuretic children.

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Material and Methods. Two groups of children, 25 enuretic and 15 nonenuretics ranging in age from 4 to 11 years, were studied on an inpatient basis at the Milwaukee Children's Hospital. Examination on admission included a complete physical, hemogram, blood urea nitrogen, urinalysis, urine culture and excretory urography. The hospital environment was standardized in that no dietary, fluid or activity controls were imposed for the 48-hour study period.

All urinary voidings for the study period were measured and recorded. In order to measure the volume of urine voided at the exact time of nocturnal incontinence in the enuretic group, a special battery powered signal device* was employed to alert the nursing staff that the child was wet. This unit, contained in a small sealed cabinet, was placed on the night stand near the head of the bed. Specifically designed rubber bed pads were connected to the signal unit and the patients allowed to sleep directly upon these covered pads. When the child urinated, a small amount of fluid (approximately 5 ml) escaped through a hole in the plastic coated diaper worn by the patient, moistening the pad and triggering the signal light. The wet diaper was promptly removed and weighed on a gram scale in order to determine the volume of urine retained in the diaper.

In this same group of enuretic children, true bladder capacities were measured at 40 cm water pressure at the time of cystoscopy under general anesthesia and the volumes recorded for comparison with their other voluntary and involuntary urinary volumes.

Clinical Data Tables. The following clinical data tables are presented in order to report the findings recorded during this study (Tables 1–3). Also the comparisons made between these two groups are included to clearly differentiate the volume varia-

* Enuresis alarms donated for this study by the S. & L. Signal Company, Inc., Madison, Wisconsin.

TABLE 1—*Enuretic clinical data chart*

Patient	Age (yrs.)	Average volume voidings (ml)	Range of voided volume (ml)	Average nocturnal volume (ml)	Bladder volume under general anesthesia
1	7	99	50–180	91	—
2	9	74	40–150	68	225
3	7	69	30–120	49	—
4	9	109	70–200	150	—
5	8	88	30–180	—	210
6	5	99	65–130	63	190
7	6	98	60–180	104	230
8	7	86	30–220	—	—
9	6	57	25–125	79	—
10	9	83	20–150	132	250
11	7	90	60–150	84	200
12	7	130	30–160	140	—
13	4	78	50–150	92	225
14	7	78	40–110	133	—
15	8	73	30–240	73	—
16	6	48	30–115	—	175
17	7	65	30–140	68	—
18	5	90	75–190	50	—
19	8	90	80–90	92	275
20	7	143	60–180	—	230
21	6	103	40–180	90	315
22	9	98	30–180	—	—
23	5	76	30–120	75	180
24	11	124	40–170	96	375
25	4	85	60–120	107	150

TABLE 2—*Nonenuretic clinical data chart*

Patient	Age (yrs.)	Average number voidings 24 hours	Functional bladder capacity (ml)
1	11	5	195
2	7	3	120
3	4	3	240
4	4	4	195
5	10	3	195
6	11	3	540
7	11	3	450
8	7	3	210
9	4	3	150
10	9	3	210
11	7	4	180
12	4	3	120
13	8	3	165
14	9	4	165
15	7	3	180

TABLE 3—*Total output of urine (ml/24 hrs)*

Enuretic			Nonenuretic		
Patient	Age (yrs.)	Total output	Patient	Age (yrs.)	Total output
1	7	705	1	11	975
2	9	1185	2	7	360
3	7	345	3	4	720
4	9	765	4	4	780
5	8	440	5	10	580
6	5	495	6	11	1620
7	6	590	7	11	1350
8	7	775	8	7	630
9	6	570	9	4	450
10	9	1160	10	9	630
11	7	450	11	7	720
12	7	690	12	4	360
13	4	625	13	8	495
14	7	780	14	9	660
15	8	730	15	7	540
16	6	625			
17	7	845			
18	5	540			
19	8	540			
20	7	715			
21	6	515			
22	9	1295			
23	5	380			
24	11	745			
25	4	510			

tions and voiding patterns established from the results obtained (Tables 4–6).

In Table 1, under a separate column, we have listed the volume range of voidings for the enuretic group. It should be pointed out that while these children occasionally have a voided volume of 180 to 240 ml, the majority of their voidings are much smaller. Their average volumes recorded for a 24-hour period are interpreted to be a more accurate measurement of their true functional bladder capacities. Also it is important to note that all of the cystoscopies were performed under general anesthesia utilizing standard nitrous oxide–fluothane–oxygen mixtures. The level of anesthesia reached during endoscopy was not of significant depth to have effect on bladder smooth muscle relaxation properties.

Discussion. Based on the results obtained in this clinical study, it is our impression that the nocturnal functional bladder capacities of the enuretics studied are very similar and in many instances almost identical to their average diurnal functional bladder capacities (Table 1). Table 3 lists the 24-hour urine output for each child in these two groups, and we note that there is very little difference in the total outputs of the patients similar in age. Age group comparisons for total output are clearly depicted in Table 6.

This report further supports earlier findings[3,5,7] in that the majority of our enuretic children have a marked daytime frequency and smaller functional bladder capacities when compared to the nonenuretic group (Tables 4–5). Of the 25 enuretics studied, 20 of these children were wet in the hospital and 15 were wet only once per night during the

TABLE 4—*Average functional bladder volumes*

Age groups (yrs.)	Enuretics (ml)	Nonenuretics (ml)	Average difference (ml)
4–6	135	180	+ 45
7–8	165	240	+ 75
9–11	180	360	+180

TABLE 5—*Number of voidings/24 hours*

Age groups (yrs.)	Enuretic range	Nonenuretic range
4–6	6–13	3–5
7–8	6–13	3–4
9–11	6–14	3–4

TABLE 6—*Average total output (ml/24 hrs)*

Age groups (yrs.)	Enuretic (ml)	Nonenuretic (ml)
4–6	540	580
7–8	640	550
9–11	1150	970

48-hour period of hospitalization. None of the enuretic patients have large urinary volumes at night and we do not feel that the etiology of enuresis can be explained on the basis of nocturnal anomalous renal secretion.

From the data recorded during cystoscopy (Table 1) it is readily apparent that our study group enuretics have a 1–2 fold increase in their total bladder capacities when measured under general anesthesia. Comparable total bladder capacities have been recorded for nonenuretic children under general anesthesia.[9] This certainly lends weight to the theory that enuresis may well be a failure or delay in the maturation of the central nervous system inhibitory centers which regulate the bladder reflex.

It is interesting to note in the recent reports by Starfield[6,8] that emphasis is placed on bladder stretching by voluntary urinary retention as a mode of therapy for enuresis. Though not specifically stated in those articles, what is really suggested, but not studied, is the fact that these children are indeed increasing their functional bladder capacities by conditioning to simulate their true bladder capacities. Thus, by whatever forms of treatment employed: bladder stretching, alarm devices, use of parasympatholytic or antidepressant-central nervous system stimulating agents, the goal of therapy is to increase the functional bladder capacity to the point of approaching the true bladder capacity.

We cannot agree with the earlier work of Muellner[5] or Hagglund[10] who state that a functional bladder capacity of 300 to 420 ml is required before enuresis can be eliminated. Our findings (which are similar to Starfield[6]) indicate that many of the nonenuretic control group as well as those from the enuretic group who were dry in the hospital (5) had significantly smaller functional bladder capacities ranging from 150 to 270 ml (Tables 1-2).

Summary. Twenty-five enuretic and 15 nonenuretic children were studied in order to compare the functional bladder capacities between these two groups. With the aid of an electronic signal device, prompt measurements of nocturnal incontinence volumes were obtained in 20 patients in the enuretic group. The findings and data recorded during this study indicate that the enuretic child has no diurnal–nocturnal difference in functional bladder capacity. Twenty-four hour urine output for these two groups is very similar with respect to age groupings. Daytime urinary frequency is documented in the bedwetting patients. Also members of the enuretic group have a one- to two-fold difference in their functional and true bladder capacities supporting the theory that enuresis is a failure or delay in maturation of the central nervous system regulatory centers which inhibit the reflex bladder arc. Total bladder capacities for these two groups are equal when age group comparisons are made. Treatment of enuresis should be by medication and techniques usually employed in order to increase the functional bladder capacity to a volume approaching the child's true bladder capacity.

The authors acknowledge the helpful assistance and cooperation rendered by the many members of the nursing staff, Milwaukee Children's Hospital, who aided in measuring and recording the numerous urinary volumes obtained during this study.

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Considerations in the Development of a Predictive System for Cancer Chemotherapy

W. H. WOLBERG, MD, University of Wisconsin Medical School, Madison, Wis: *Arch of Surg* 102:344–347 (Apr) 1971

There is evidence that biochemical factors determine tumor sensitivity to drugs. Some of the factors which can be evaluated *in vitro* appear to correlate with patients' response to fluorouracil chemotherapy. However, there is evidence that destruction of a large portion of the malignant cells may escape clinical detection. In some instances destroyed tumor tissues are replaced with fibrous tissue. In other instances the rapid overgrowth of biochemically resistant tumor cells exceeds the rate at which sensitive cells are killed. This can be demonstrated in an experimental system. There can be destruction of 75% of a tumor cell population and yet total tumor cell number increase due to logarithmic overgrowth by resistant cells. □

NEW DRUG RESEARCH: Calusterone

Calusterone: Caused objective remissions in 14 of 22 women with far advanced, hormone refractory breast cancer. Remissions lasted from 3 to 20 months. The drug was given in a dose ranging from 150 mg to 300 mg per day. Calusterone is 7 beta, 17 alpha-dimethyltestosterone. By Dr. Gilbert S. Gordon and associates, U of Calif School of Medicine, San Francisco.—AMERICAN DRUGGIST, October 19, 1970 □

Alteration of Purine Control Mechanisms in Patients with the Lesch-Nyhan Mutation

By Paul J. Benke, MD, Madison, Wisconsin

DR. PAUL J. BENKE presented the winning resident-intern paper at the Annual Meeting of the State Medical Society of Wisconsin, May 14, 1970, in Milwaukee. He was given $100 as the Wm. S. Middleton Award.

THE LESCH–NYHAN SYNDROME is characterized by spasticity, mental retardation and choreo-athetosis, and clinically the disorder resembles cerebral palsy. Frequently one additional feature is an unusual self-mutilation, in which affected patients chew on their fingers or lips. This behavior arises as an impulse when patients are upset, and it is interesting that they are more comfortable when restrained and protected against themselves.

The metabolic defect has been described by Seegmiller and his associates, and it is loss in the ability to convert the free purine bases hypoxanthine and guanine to their respective mononucleotides. Conversion of the purine base adenine to its mononucleotide is preserved. The enzyme locus for the defect is located on the x-chromosome, so that males are affected and females are carriers. Loss of this enzyme leads to accelerated production of uric acid.

We studied a large family with this problem at Wisconsin, and three years ago one of our heterozygous females became pregnant. Amniocentesis was performed at five months gestation and diagnosis of enzyme deficiency in a male was suggested by studies in the laboratories of Dr. Robert DeMars and Dr. Glorio Sarto. At term the patient delivered twin males who proved to be identical. We confirmed the diagnosis by assay of the enzyme in red cell hemolysates.

The twins were born in December 1968, and at this time several factors were known about altered metabolism in these patients. First, they had a severe failure to thrive, and this had contributed to the death of several patients. Control of the hyperuricemia with allopurinol does not prevent development of neurologic dysfunction. Also, they occasionally developed a megaloblastic anemia which was responsive to adenine. Work had been done on mutant fibroblasts by Drs. Felix and DeMars which suggested that cells with the enzyme defect required either excess folic acid or adenine to grow. We were greatly concerned about the administration of adenine to newborn infants because it breaks down to a metabolite which is toxic to the renal parenchyma. We then decided to give adenine to one twin, and folic acid to both twins. The twins were of unequal birth weight, and it was not possible nor desirable to use one as a control.

This information suggested several experiments, which were then performed on the affected twins' first cousins who are patients at Central Wisconsin Colony.

In a control experiment, glycine-l-C^{14} was administered to the Central Colony patients with the enzyme defect, and the daily uptake into urinary uric acid was studied. Folic acid was given to one patient and monosodium glutamate to the second, and a repeat glycine-l-C^{14} incorporation into urinary uric acid was performed. In a third experiment, low-dose adenine, 10 mg/kg/day was given to one patient and high-dose adenine 40 mg/kg/day was given to the second, and glycine-l-C^{14} incorporation into uric acid was studied.

The rationale for these experiments can be seen when we examine normal metabolic pathways in purine metabolism (Fig 1). The enzyme defect is the loss of the hypoxanthine and guanine salvage pathway, which is carried out by one enzyme. As mentioned the adenine salvage pathway is intact, and adenine is a way of getting around the metabolic block. The biosynthetic pathway of purines is probably accelerated since purines are lost by normal metabolic degradation to hypoxanthine, and then cannot be reutilized. With the excess purine synthesis, purine precursors may be consumed or at least be rate limiting for purine synthesis.

In these experiments we found that folic acid stimulated glycine incorporation into uric acid by 13% and glutamate stimulated incorporation by 27%. Adenine will increase the intracellular nucleotide pool and may decrease *de novo* synthesis of purines by feedback mechanisms as measured by glycine

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incorporation into uric acid. This proved to be the case; the low-dose adenine suppressed *de novo* synthesis of uric acid by 5% and delayed glycine-C^{14} incorporation in uric acid, and high-dose adenine decreased incorporation by 20% and decreased incorporation toward normal. These approaches to therapy did not change the neurological status of the fully developed syndrome.

This information further expanded our knowledge on the purine metabolism in the Lesch–Nyhan patient. Administration of purine precursors boost the already accelerated *de novo* purine synthesis still further. Indirectly it suggests that the excess consumption of precursors, such as the carbon donor folic acid, might make these metabolic intermediates rate limiting.

The adenine data is also useful. 10 mg/kg/day, the dose of the one twin, is not enough to strongly diminish purine synthesis. The toxic metabolite of adenine, 2-8 dihydroxyadenine, was identified in the urine by Dowex chromatography. Presumably it arises by action of xanthine oxidase on adenine, and we have found that allopurinol, an xanthine oxidase inhibitor, prevents its formation. If we had it to do over again, the data suggests that 40 mg/kg/day is a better dose in decreasing the accelerated synthesis.

The twins are 18 months old, and in some ways doing well. However, they are spastic and show delayed neurological development and are significantly affected.

The older untreated cousins are more severely affected, but it is important to note that comparisons are difficult because a few patients with the complete enzyme defect do better for unknown reasons. We do not know whether the type of therapy I have discussed today would have prevented the neurological picture if given to the mother during pregnancy. Although cells with the enzyme defect are treatable in tissue culture, there are different problems of purine pools and transport in the fetus and newborn infant.

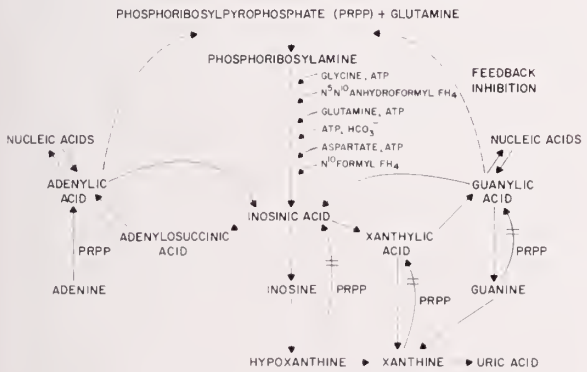

Fig. 1—Pathways of purine metabolism. The enzymatic defect in the Lesch–Nyhan syndrome is loss of an important salvage enzyme which converts the purine base to the mononucleotide (block indicated by ≠). The adenine pathway is intact. Trapping of inosinic acid in hypoxanthine leads to secondary acceleration of purine synthesis from simple precursors. Two different forms of folic acid (FH4) are involved.

In summary, we have attempted to influence an inborn error of metabolism in identical twin males; and although it is early to say how much good we have done, we can say that we have not prevented the disorder. The biochemical experimentation presented today is of help in understanding how this therapy is affecting the accelerated purine metabolism in those infants and may be important as a better biochemical approach to therapy evolves. □

Fractures of Pterygoid Processes Accompanying Severe Facial Bone Injury

J. DeB. UNGER, MD and G. F. UNGER, MD, VA Center, Wood, Wis: *Radiology* 98:311–316 (Feb) 1971

Twelve patients with severe maxillofacial fractures of the Le Fort II, Le Fort III or zygomaticomaxillary compound types were examined by multidirectional laminography as a supplement to the conventional radiographic study. All patients sustained either unilateral or bilateral fractures of the pterygoid laminae of the sphenoid bone. These fractures were usually difficult and frequently impossible to detect on the conventional films.

Pertinent anatomical detail is discussed and consideration is given to both observed and potential complications. □

Methyl Chloroform Intoxication

RICHARD D. STEWART, MD, Medical College of Wisconsin, Milwaukee, Wis: *JAMA* 215:1789–1792 (Mar) 1971

Methyl chloroform (1,1,1-trichloroethane) is a widely used solvent in the United States. Excessive absorption of this substance through the lungs or gastrointestinal tract produces central nervous system (CNS) depression proportional to the amount absorbed. Mild liver and kidney dysfunction may occur transiently following recovery from CNS depression. The diagnosis of exposure is established by specifically identifying the solvent in the expired breath. Serial breath analyses allow the estimation of the total amount absorbed. The treatment is supportive, to combat the effects of CNS depression. The principles of diagnosis and treatment are illustrated by four cases of accidental vapor exposure.

The tentative diagnosis of methyl chloroform intoxication is usually suggested by the history, the physical signs, and the clinical course. The definitive diagnosis of exposure to methyl chloroform can be established unequivocally by a quantitative determination of the compound in the patient's blood, tissue, or expired breath. Currently, breath analysis is the most rapid and most sensitive detection method to employ. □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Professor of Clinical Pharmacology, Medical College of Wisconsin, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Transfusions Today

By Myrna Traver, MD, Madison, Wisconsin

BLOOD TRANSFUSION has become an indispensable part of medical practice. Current annual blood usage in the United States is approximately 6.5 million units and is continually increasing. Unfortunately, the pool of blood donors is not enlarging to keep pace with the rising demand. At the present time most of this blood is transfused as whole blood: blood from one donor is used to treat a single patient. One relatively simple approach to the problem of blood shortage is to increase the use of blood components instead of whole blood. Through this mechanism the available supply can be immediately increased at least four-fold: one unit of whole blood can be separated to provide red cells for one patient, platelets for a second, factor VIII for hemophiliac, and the remaining plasma can be transfused directly to a patient in shock or sent to a commercial fractionation firm for separation of albumin, fibrinogen, gamma globulin, and specific immune globulins. And, not surprisingly, the patient who receives only the component that he needs receives better treatment than with the "shot gun" whole blood transfusion.

Component therapy begins with the substitution of red cell concentrates for whole blood whenever possible, thus making platelets and plasma available for other patients. Most transfusions are given for one reason: to improve the patient's oxygen-carrying capacity. The only component of whole blood which can do this is the red cell. It is logical, then, to transfuse only red cells. Many practicing physicians were trained during the period when whole blood was the only form in which red cells could be given. Considerable educational effort is needed to break the long-standing habit of ordering whole blood when only red cells are needed. It has been estimated that packed red cells should be given in approximately 60–80% of the cases in which whole blood is used today.

Of course the physician faced with severe, acute hemorrhage (traumatic, operative, or medical) accompanied by shock should replace what the patient has lost—whole blood, preferably fresh and compatible by cross-match. But such cases are the only remaining indication for transfusion of whole blood. Less massive bleeding with loss of 1000 to 1500 ml of blood can usually be treated adequately with packed red cells and electrolyte solutions such as lactated Ringer's solution.

Packed red cells. In cases of chronic anemia packed red cells are the most efficient way to raise the hematocrit. In spite of anemia, the patient is usually hypervolemic due to an increase in plasma volume. Transfusion of 315 ml of plasma-anticoagulant solution contained in a unit of whole blood does nothing to improve the anemia and further burdens the heart and kidney. Rapid infusion of whole blood may in fact produce acute heart failure in patients with preexisting heart disease. Removal of 220 ml of plasma-anticoagulant allows infusion of the same 200 ml of red cells with a total blood volume increase of only 300 ml. If the plasma is removed from the whole blood just before transfusion, the amounts of sodium, potassium, acid, citrate, and ammonia are reduced by 65–70%. This is helpful in patients with cardiac, renal, and hepatic diseases. Transfusion reactions due to allergens or plasma protein antigens are usually decreased.

Red cell concentrates (packed red cells) can be prepared in several ways. No special equipment is needed if the cells are allowed to sediment over a period of three to four hours in the refrigerator. The supernatant plasma can then be expressed into a satellite container, leaving a red cell concentrate with a hematocrit of 70% or more. The characteristics of this red cell preparation, compared with whole blood, are given in Table 1. Since the original blood container has been opened, there is some chance of bacterial contamination, and the red cells must be transfused within 24 hours. The plasma may be pooled and sent to a commercial processor for fractionation.

Platelets. Platelets and labile plasma clotting factors can be salvaged if the red cells are separated

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TABLE 1*—*Comparison of the constituents of stored whole blood and packed red blood cells (at 21 days)*

	Whole Blood	Packed Red Blood Cells
Volume	517.5 ml/unit	300 ml/unit
Red blood cell mass	200 ml	200 ml
ACD solution (citrate)	67.5 ml	22 ml
Plasma	250 ml	78 ml
Albumin	12.5 gm	4 gm
Globulin	6.25 gm	2 gm
Total protein	48.75 gm	36 gm
Hemoglobin	30 gm	30 gm
Hematocrit	39%	70%
Plasma sodium	45 mEq	15 mEq
Plasma potassium	15 mEq	4 mEq
Plasma acid (pH 6.6)	80 nanoEq	25 nanoEq
Plasma NH_3	2159 microgm	680 microgm

*Reprinted by permission from "Blood Component Therapy" published by the American Association of Blood Banks, 1969.

immediately after the blood is collected. The blood must be taken into a special donor set which has several satellite bags attached, thus allowing separation of the components within a closed system. The red cells are separated by immediate centrifugation of the still-warm donor blood. The speed and time of centrifugation are adjusted so that the red cells are sedimented while the platelets remain in the supernatant plasma. The resulting red cell preparation has a hematocrit of 70% and a shelf life of 21 days. The plasma is centrifuged again at higher speed to pack the platelets. All but 15–20 ml of the plasma is removed to a third container. The platelets are resuspended in the remaining plasma by gentle manipulation. They may be transfused immediately or stored at room temperature for as long as 96 hours. The platelet concentrate contains 70–80% of the platelets present in the whole blood, or about 1×10^{11} platelets if the donor's platelet count was 250,000/mm^3. The plasma is then frozen to —20 C to preserve the activity of Factors VIII and V.

Since technics for separating and concentrating platelets have been developed, it has become possible to provide supportive therapy for patients with thrombocytopenia due to aplastic anemia, acute leukemia, and bone marrow suppression due to chemotherapy of malignancies. Platelet transfusion is indicated if the patient is actively bleeding into the skin, gastrointestinal or genitourinary tracts or brain, or if the platelet count is below 10,000 and the risk of hemorrhage high. Dosage can be calculated from the following data. In a patient with a body surface area of one square meter, infusion of one unit of platelet concentrate should produce an increase of at least 15,000 in the platelet count taken one hour after transfusion. Thus:

$$\text{Increase in platelet count} = \frac{15{,}000 \times \text{number of units infused}}{\text{body surface area (m}^2\text{)}}$$

For example, a 5′11″ male weighing 155 lb has a body surface area of 1.9 m^2. To raise his platelet count from 10,000/mm^3 to 50,000/mm^3 will require 5 units of platelet concentrate. This dose is given two or three times a week for maintenance therapy. Lesser increases in the platelet count are seen in the presence of bleeding, fever, or infection, and the dosage must be increased in such cases. The therapeutic effect may be judged by cessation of bleeding and observation of clot retraction as well as the platelet count.

Since the ABO antigens are present on platelets, the platelet donors should be of the same ABO group as the patient. If group-specific platelets are not available, group O platelets may be used for a patient regardless of his ABO group. Rh antigens are probably not present on platelets, and matching Rh types of patient and donor is not important for platelet survival. However, there is always some contamination of the platelet preparation by red cells. If the patient is an Rh negative woman in the childbearing age, and she has a reasonable chance of recovery, it may be important not to jeopardize future pregnancies by immunizing her to the Rh antigen. In such a case, platelets should be obtained from Rh negative donors if at all possible.

Patients who receive multiple platelet transfusions from random donors over a period of weeks generally become refractory to treatment after about eight weeks. Platelet concentrates are no longer effective in arresting bleeding, platelet count increments are less than 6,000/mm^3, and the patient has a nonhemolytic reaction to platelet transfusions. In these cases the patient usually has produced antibody to the HL–A antigens which also are carried on the platelets. Transfusion of platelets from an HL–A identical donor, usually a sibling, will be effective in these patients. Plasmapheresis will be necessary to obtain sufficient numbers of platelets from the donor. Two or three units of platelet concentrate can be taken from an adult donor using this technic, and the procedure may be repeated twice weekly.

There are also three antigen systems which are found only on platelets—Pl-A, Pl-E, and Ko. These are usually ignored in platelet transfusion therapy except in cases of neonatal thrombocytopenic purpura. This disease is analogous to hemolytic disease of the newborn: the mother has been immunized to a platelet antigen, usually Pl-A^1, and the antibody crosses the placenta and destroys the child's platelets. Since 97% of random donors are Pl-A^1 positive, the most readily available donor of compatible platelets is the mother herself.

Plasma. All clotting factors except platelets are present in fresh frozen plasma. It may be stored at —20 C for up to one year before use. Its chief uses are: (1) as a blood volume expander to be used in cases of shock until whole blood can be crossmatched, (2) in the treatment of single factor clotting deficiencies when more concentrated preparations are not available, and (3) in the treatment of multiple factor deficiencies, as in liver disease with coagulopathy.

A patient should ideally receive plasma from a donor of the same ABO group. If this is not avail-

TABLE 2*—*Approximate percentages of original plasma content of clotting factors recovered in cryoprecipitate*

Factor		% Recovery
VIII	antihemophilic globulin (AHG, AHF)	56
I	fibrinogen	23
II	prothrombin	1.5
V	proaccelerin	1.0
VII	proconvertin	1.8
IX	PTC	5.5
X	Stuart-Prower	1.4
XI	PTA	1.1
XII	Hageman	2.0

*Reprinted by permission from "Blood Component Therapy" published by the American Association of Blood Banks, 1969.

able, group AB plasma may be given to any patient regardless of his ABO group. Since group AB plasma is often in short supply, its use in patients who are not group AB should be reserved for valid emergencies. The Rh type of the donor is not important in most cases. However, there are usually a few red cells in the plasma and an Rh negative patient may be immunized by the Rh antigen on the red cell stroma. If the patient is a woman in the childbearing age, one may choose to match Rh types to avoid immunizing her.

Cryoprecipitate. Although about 80% of the Factor VIII activity is recovered on thawing, whole plasma is not the product of choice in treatment of hemophilia A. A more concentrated preparation is easily made by taking advantage of the low solubility of Factor VIII at low temperatures. The frozen plasma is taken from the freezer and placed in the refrigerator (4 C). After 20–24 hours the plasma will have thawed, and a gummy precipitate remains in the bottom of the bag. The supernatant plasma is expressed into another bag, leaving 5–10 ml behind for dissolving the precipitate before administration. The cryoprecipitate is refrozen until used. This product contains 550 mg of protein, of which 190 mg are fibrinogen, and approximately 130 units of Factor VIII activity (55% of that originally present in the fresh plasma). Percentage recovery of these and other clotting factors is given in Table 2. There are traces of all plasma proteins present. It is obvious from the table that this product is of no value in clotting disorders other than hemophilia A. Therefore a specific diagnosis should be made before cryoprecipitate therapy is begun.

The severe hemophiliac usually has levels of Factor VIII activity less than 1%. Hemarthrosis can usually be controlled by raising the activity to 5–10% of normal. If surgery is required, levels must be maintained at 30–60% of normal for at least 10 days postoperatively. The dosage of cryoprecipitate can be calculated from the desired activity level, the patient's plasma volume, and the average activity of 130 units/bag of cryoprecipitate:

$$\text{no. of bags} = \frac{\text{plasma vol (ml) x increase in activity (\%)}}{\text{130 units/bag x 100}}$$

$$\text{plasma volume (ml)} = \text{body weight (kg) x 0.04 x 1000}$$

The dose must be repeated every 12 hours. It may be necesary to give twice the above amount for the initial dose.

Optimally the patient should receive cryoprecipitate from a donor of the same ABO group. Although the isoagglutinins are not concentrated during preparation of the cryoprecipitate, a group A patient who has received a large number of group O cryoprecipitates may eventually show a weakly positive direct Coombs test due to the anti-A from the donors.

More highly concentrated preparations of Factor VIII can be prepared by commercial fractionation technics with a potency as high as 100 units/ml. Because of their relatively high cost, one may choose to reserve them for patients with circulating AHF inhibitors in whom massive doses—several thousand units—are needed to neutralize the inhibitor.

Other coagulation factors. The Factor VIII-deficient supernatant plasma remaining after cryoprecipitate preparation contains normal levels of other stable coagulation factors, including Factor IX. Therefore it is valuable in treating the coagulopathy of liver disease, hemophilia B (Christmas disease), or other more rare factor deficiencies.

A concentrated commercial preparation of Factors II, VII, IX, and X containing 500 units of Factor IX activity in 20 ml is available for hemophilia B patients who cannot tolerate the blood volume expansion which accompanies whole plasma transfusion.

Proteins. Plasma which is not suitable for treatment of coagulation defects is a good source of albumin or protein fractions administered for their oncotic effect. Albumin is available as a 5% solution in buffered saline or as a 25% salt-poor solution. A less highly purified (and cheaper) preparation referred to as plasma protein fraction is a 5% protein solution containing approximately 88% albumin and 12% alpha and beta globulins. These are useful in treatment of shock due to various causes and replacement of protein and fluid loss in burns and peritoneal lesions. The 25% albumin solution may be used for supportive therapy of hypoproteinemia, but its effect is usually transient, especially in protein-losing states. Although albumin and plasma protein fraction are prepared from pooled plasma, the hepatitis risk is low. It is thought that the hepatitis virus is inactivated during the preparation which includes heating to 60 C for 10 hours.

White cells: Up to this point there has been no mention of the white blood cell. In most transfusions the presence or absence of donor white cells is of little consequence. Occasional patients, however, suffer severe febrile transfusion reactions to whole blood or ordinary packed red cells due to the presence in their plasma of antibodies to white cell antigens. They have been immunized by previous transfusions or pregnancies. In such cases it is necessary to remove 90–95% of the donor white

cells to prevent the febrile response. There are several methods available:

(1) The simplest is inverted centrifugation of blood less than 24 hours old. The unit of blood is turned upside down before centrifugation. This allows the red cells to be removed from the bottom without disturbing the "buffy coat." A visible buffy coat is usually formed after prolonged centrifugation, but many white cells are intermixed with the upper portion of the red cells. The red cells to be transfused are removed from the bottom of the bag, leaving behind the upper 25% of the red cells.

(2) Warm, heparinized (rather than citrated) donor blood may be passed through a filter of nylon fibers to which the granulocytes will adhere. There is little red cell loss with this method, but lymphocytes are not removed.

(3) Washing the red cells several times with isotonic saline solution is sometimes used, but this method is more efficient in removing plasma proteins than white cells.

(4) The ultimate method of choice for white cell removal is freezing and thawing red cells. This procedure is presently outside the scope of all but the largest donor centers.

There are occasions—granulocytopenia with sepsis, for example—in which granulocyte transfusions would be desirable. Success in this area has been hampered by the biologic and technical problems in obtaining sufficient numbers of white cells from normal donors. The number of granulocytes released by the bone marrow each day has been estimated at 160×10^7 cells per kilogram, or 3.2×10^{10} cells for a 20-kilogram child. If the source of donor granulocytes is normal adults, we have access only to the circulating granulocyte pool of approximately 30×10^7 cells/kg, or 2.1×10^{10} cells in a 70-kg donor. The standard double unit leukapheresis procedure processes only 20% of the donor's blood volume, so approximately 0.4×10^{10} cells could theoretically be obtained from one donor. However, the fractionation methods are only about 25% efficient, and the actual yield is in the range of 0.1×10^{10} cells per donor. Thus we would need at least 30 donors per day for a 20-kg child with no intrinsic granulocyte production. Greater numbers of white cells can be obtained from donors with chronic granulocyte leukemia if the patient's condition justifies the use of such cells.

An excellent reference on modern transfusion therapy is the "Physician's Handbook of Blood Component Therapy" published by the American Association of Blood Banks and available from its office (30 North Michigan Avenue, Chicago) for $1.00 per copy. □

Blood Pressure in Patients with Spinal Cord Injury

G. M. KUNIN, MD, Veterans Administration Hospital, Madison, Wis: *Arch Intern Med* 127:285–289 (Feb) 1971

A survey was conducted among 152 adult male paraplegic and quadriplegic patients known to have chronic urinary tract infection. Many had x-ray film evidence of renal involvement, but few had elevated serum creatinine levels. Elevated blood pressure was rare in these patients. Review of the literature confirms this finding, but emphasizes the major role of hypertension and pyelonephritis in those who die as a result of the spinal cord injury. It would appear that hypertension is a late manifestation of severe pyelonephritis and amyloidosis. These results may explain why it has been difficult to clearly associate bacteriuria (which is very common in the general population) with hypertension, but relatively easy to detect bacteriuria among hypertensive patients. Prevention of hypertension remains an important goal for patients with recurrent or persistent urinary tract infections. □

Reticuloendotheliosis with Niemann–Pick Type Foam Cells in Bone Marrow and Spleen

L. F. VITALE, MD, N. T. SHAHIDI, MD, and C. H. ALTSHULER, MD, University of Wisconsin Medical School, Madison, Wis: *Arch Path* 90:218–221 (Sept) 1970

Hepatosplenomegaly associated with foam-cells (honeycombed appearance) is highly suggestive of Niemann–Pick disease. An 11-month-old infant presented with hepatosplenomegaly, fever, thrombocytopenia and foam cells in the bone marrow. Although the initial diagnosis based on the examination of the bone marrow and spleen strongly suggested Niemann–Pick disease, an analysis of the phospholipid in the spleen did not substantiate this diagnosis. As compared to normal values, the total lipids were slightly reduced, but the mucopolysaccharides moderately increased. In addition, the patient who died six months later was found to have a chromosomal abnormality in the cultured cells of the bone marrow. Postmortem findings showed generalized infiltration with mononuclear cells identified as histiocytes. On the basis of this finding, a diagnosis of malignant reticuloendotheliosis was made. □

Endothelial Cytoplasmic Inclusions

J. M. B. BLOODWORTH, JR, MD and WELDON D. SHELP, MD, University of Wisconsin Medical School, Madison, Wis: *Arch Path* 90:252–258 (Sept) 1970

Cytoplasmic inclusions, visible by electron microscopy, occur quite frequently in endothelial cells of patients with disseminated lupus erythematosus. These inclusions are approximately the size of a mitochondrium and are composed of many intertwining tubular structures measuring from 1,000 to 1,500 Angstroms in length and 190 to 225 Angstroms in diameter. These structures are thought to represent either virus or, more likely, virus extrusions. Previous investigators have reported that 100% of lupus patients reveal these "virus-like" inclusions. Some investigators have suggested that they occur only in lupus.

We studied 300 consecutive biopsies in the laboratory for experimental pathology of the Madison V. A. Hospital. Fifty-five of these patients had disseminated lupus erythematosus and 62% revealed the "virus-like" inclusions in the endothelial cytoplasm. Of the 245 non-lupus patients, 2.4% showed "virus-like" inclusions in the endothelial cytoplasm.

Although we are not able to confirm other investigators' reports that 100% of lupus patients contain "virus-like" inclusions in their endothelial cytoplasm and that they are specific for lupus, still, the presence of "virus-like" inclusions is strongly suggestive of the diagnosis of disseminated lupus erythematosus. □

Selective Reduction of Incarcerated Inguinal Hernia

H. M. KAUFFMAN, JR., MD, Medical College of Wisconsin, Milwaukee, Wis; and D. P. O'BRIEN, MD, Medical College of Virginia, Richmond, Va: *Amer J Surg* 119:660–673, 1970

Selective reduction of incarcerated hernias is a low-risk procedure that permits postponement of surgery in poor-risk patients.

Reduction should not be attempted when there is any possibility of strangulated or gangrenous bowel or when the incarcerated hernia might contain an ovary. Abdominal tenderness, peritoneal irritation, hypoactive or absent bowel sounds, and a tender hernia with local inflammation are indications that there may be nonviable bowel. If there is any question of bowel viability, prompt surgical exploration is indicated.

Although there is a risk from attempted reduction of incarcerated inguinal hernias, the risk is small when compared with that of emergency surgery, particularly in the elderly patient or in the pediatric patient with respiratory tract infection.

Whenever symptoms of intestinal obstruction continue after hernia reduction, there may have been reduction en masse. The most significant danger of reduction en masse is the failure of the physician to recognize it. Prompt surgical intervention is indicated.

Pediatric incarcerated inguinal hernias can often be reduced without the use of drugs; however, sedation facilitates the procedure. Although muscle relaxants, such as methocarbamol, are not often needed, they are particularly useful in the child who is a poor surgical risk because of associated problems. In adults, drug therapy has a beneficial effect in achieving hernia reduction; an analgesic and muscle relaxant used together and administered intravenously are especially effective.

Among a group of 162 patients with incarcerated inguinal hernias, moderate degrees of pressure were applied in an attempt to reduce the hernias in 48 children and 81 adults. Of the total 129 reductions attempted, 87 (67%) were successful; however, only one-fourth of the hernias were reduced without the use of barbiturates, narcotics, or muscle relaxants. Attempts at hernia reduction were made only when the hernias seemed to contain viable bowel. There was no instance of attempted reduction of nonviable bowel. Of the pediatric patients who underwent attempted reduction, four-fifths were less than 2 years old; more than half of the adults were over 60 years of age. A significant number of the 129 patients were poor risks.

The duration of incarceration was of no value in predicting whether the hernia would be reduced. Moreover, neither fever nor leukocytosis was predictive of nonviable bowel. However, there was a more positive correlation when the white blood cell count was over 20,000 per cubic millimeter.

Attempted or successful reduction of the hernias was not contributory to any patient's death, and frequently, surgery could be postponed in poor-risk patients until they had improved. □

NEW DRUG RESEARCH

Chlorpropamide: Produced anti-diuretic activity within 24 hours in 4 patients suffering from idiopathic diabetes insipidus with maximal effect appearing in 2 to 3 days. The patients were treated successfully for as long as 19 months. By Dr. C. Thiffault and associates, Quebec, Ontario, Can.—AMERICAN DRUGGIST, October 19, 1970 □

Trimethoprim: Cured various salmonelloses in 12 patients when used in combination with sulfamethoxazole. By Dr. H. A. Meyer, Zollikerberg, Switzerland.—AMERICAN DRUGGIST, Jan. 11, 1971 □

Benzquinamide: Produced excellent responses in 6 of 7 patients suffering from vomiting, when given by parenteral injection. In 18 patients given the drug orally, 13 showed excellent responses and 1 a good response. By Dr. Joseph Medoff, Thomas Jefferson U, Philadelphia.—AMERICAN DRUGGIST, Jan. 11, 1971 □

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Infectious Mononucleosis Complicated by Hemolytic Anemia and Thrombocytopenic Purpura

By Ray H. Clark, MD, Bernard C. Korbitz, MD and William S. Cline, MD, Madison, Wisconsin

THROMBOCYTOPENIC PURPURA and hemolytic anemia both have been reported to occur in patients with infectious mononucleosis, but the simultaneous occurrence of these two complications appears to be very unusual. This is a report of a patient presenting with thrombocytopenic purpura accompanied by hemolytic anemia.

Case Report. A 19-year-old college student was admitted with the chief complaint of red spots on her lips, face, and legs of one day's duration. She had been in good health until two weeks prior to admission, when she had a transitory illness characterized by malaise, fever, and mild cough which cleared within two to three days. She denied any history of drug use or exposure to toxic chemicals. There was no history of swollen or painful joints and no family history of a bleeding disorder.

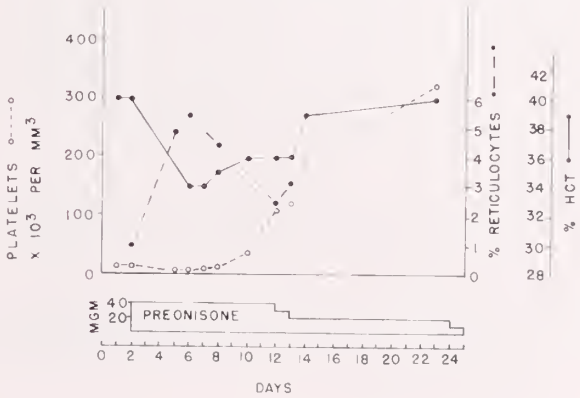
Physical examination revealed petechiae on the face, mouth, tongue, and legs. There was no lymphadenopathy, hepatomegaly, or splenomegaly.

Her laboratory values are seen in Figure 1. Initial hematocrit was 40% and platelet count 12,000. The white blood cell count was 6,100 with 25% segmented neutrophils, 6% bands, 35% typical lymphocytes, 32% atypical lymphocytes and 2% monocytes. The sedimentation rate was 18 mm/hr uncorrected and the prothrombin time 83%. Normal blood chemistries included glucose, blood urea nitrogen, uric acid, cholesterol, calcium, phosphorus, alkaline phosphatase, total protein, and albumin. The bilirubin was mildly elevated at 1.8 mg/100 ml total. The serum glutamic oxaloacetic transaminase was 64 International units and the serum lactic dehydrogenase 332 International units. The venereal disease test for syphilis was negative and the antistreptolysin titer was less than 16 Todd units. Lupus erythematosus preparations were negative three times. Antinuclear bodies were nonreactive. Serum protein electrophoresis was within normal limits. Admission chest x-ray film was reported as negative.

A bone marrow examination was performed showing plentiful megakaryocytes and erythroid hyperplasia. Atypical lymphocytes similar to those found in the peripheral smear were also noted.

Because of thrombocytopenia, prednisone was begun on the second hospital day at 40 mg daily. On the fourth hospital day, her hematocrit fell to 34%. A reticulocyte count was 5.4%. The direct and indirect Coombs' were negative. Total bilirubin was 1.5 mg/100 ml with 0.4 direct reacting. A heterophile antibody titer was positive at a dilution of 1:512. Stool tests with guaiac were negative. No anti-i was found in her serum. Serum haptoglobin on starch gel electrophoresis[1] was reduced.

Fig. 1—Summary of levels of platelets, reticulocytes, and hematocrits.



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On the day of discharge, 14 days after onset of symptoms, her hematocrit was 39% and reticulocyte count 3.9%. The platelet count was 190,000. The white blood cell count was 5,500 with 41% segmented neutrophils, 1% bands, 2% eosinophils, 46% typical lymphocytes, and 6% atypical lymphocytes, 2% monocytes, and 2% metamyelocytes. The heterophile had decreased over the hospitalization to a dilution of 1:128 (absorbed). Prednisone was reduced and stopped by the twenty-fourth day.

Discussion. Approximately 44 prior case reports of hemolytic anemia in infectious mononucleosis have appeared in the literature. Deaton et al[2] reviewed 39 cases and several others[3–6] have been reported since. The etiology of the hemolysis has remained a question. Both Coombs' positive and Coombs' negative anemias have been reported. Cases associated with Anti-i cold antibody have been noted.[3, 6–8] Hossaini,[6] reporting a case of hemolytic anemia associated with Anti-i, also screened 52 cases of uncomplicated infectious mononucleosis and found Anti-i agglutinin in 69.2%, only one, however, being a significant titer. Our patient was Coombs' negative and had no Anti-i.

Mild thrombocytopenia in infectious mononucleosis is frequent, but purpuric manifestations are rare. Carter[9] demonstrated some degree of thrombocytopenia in 50% of 57 patients, none having counts below 63,000 and only 5 being less than 100,000. Cantow and Kostinas[10] found that 24.4% of 41 cases of infectious mononucleosis had thrombocytopenia occurring primarily during the third to fifth week of the illness. None of these patients developed purpura. Clarke and Davies[11] reviewed 32 cases with severe thrombocytopenia in 1964. Further cases[12–14] have been noted since that time.

The combination of thrombocytopenia and hemolytic anemia has also been reported. Casey and Main[15] reported 3 cases which had hemolytic anemia and thrombocytopenia without purpura. Smith et al[16] reported a case of hemolytic anemia with thrombocytopenia, again without purpura. A case of severe thrombocytopenia with fatal cerebral hemorrhage[17] appears also to have had a possible hemolytic anemia, the hematocrit falling from 44% to 24% in 6 days with no mention of bleeding. Our present patient presented with thrombocytopenic purpura and shortly thereafter developed hemolysis.

The cause of the thrombocytopenia in this disorder remains unknown. Freeman and Wakefield[18] demonstrated a platelet agglutinating factor in one patient. Goldstein and Porter[17] found a platelet lysing antibody in their patient. Smith et al[16] also noted platelet antibodies in one patient.

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Malignant Hemangioendothelioma of Bone in Childhood

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Amer J Dis Child 121:410–414 (May) 1971

Benign vascular tumors are frequently encountered in infancy and childhood. Malignant vascular tumors, however, are exceedingly rare. An example of malignant hemangioendothelioma in a 16-month-old infant involving the vertebral bodies T 8 to L 1 with extension to the extra-dural space producing spinal cord compression is reported. Eight additional cases from the literature of malignant hemangioendothelioma of bone in children are reviewed. Of the nine cases reported, six have pursued a downhill course. Sites of metastases included lungs, lymph nodes, brain, and other bones. Three patients, however, have had long-term survival. These cases were all treated by radical surgery as well as radiation in one case. □

Sleep and Disease

By Frank R. Freemon, MD, Milwaukee, Wisconsin

THIS COMMUNICATION REVIEWS recent advances relating sleep and different disease states. The rapidly expanding field of sleep research cuts across traditional clinical disciplines to involve all physicians from neurologist to urologist.

Sleep studies are performed by monitoring the electroencephalogram and eye movements throughout the course of the night. As a person becomes drowsy, his background EEG alpha activity disappears and he enters sleep stage 1 which is actually akin to drowsiness. When K-complexes occur in the EEG recording, he is in stage 2. With the appearance of delta waves he enters stage 3; and when this slow activity becomes continuous, he is in stage 4. About two hours after falling asleep, the person experiences an entirely different type of sleep characterized by a low voltage EEG record and rapid eye movements. This is called REM sleep and is clearly differentiated from the earlier type of sleep, called nonREM with substages 1, 2, 3, and 4. Four to 5 REM periods each 15 to 30 minutes in duration occur per night to account for about 25 percent of a night's sleep. Specific scoring criteria have been devised to divide formally an all-night EEG record into REM and nonREM sleep stages and to subdivide nonREM into its 4 substages.[1]

REM sleep, which also is called D-state and paradoxical sleep, can be differentiated from nonREM sleep on the basis of differences in heart rate, respiration, penile erection, tension of certain muscle groups, and ongoing mental activity as well as by eye movements and the EEG record. Sleep mentation is sampled by waking the sleeper and asking him what was running through his mind prior to awakening. NonREM mentation is characterized by recurring thoughts, such as working over or rehearsing an idea. REM mentation is a visual drama with many fantastic events accepted as real by the sleeper. While nonREM mentation is not devoid of affect, REM mentation usually contains more emotion. Both types of mentation relate in some way to events of the preceding day and frequently dissipate rapidly from memory.[2]

Modern sleep research has helped to define and clarify the confusing disorder known as narcolepsy. Patients carrying this label have varied from the medical student who sleeps in lectures to Joe, the Fat Boy of Dickens' *Pickwick Papers,* who falls asleep while knocking on the door. Sleep research has suggested a division of narcolepsy into two categories. Patients with one type of narcolepsy suffer sleep attacks, cataplexy (sudden weakness), hypnogogic hallucinations (vivid mentation at nocturnal sleep onset), and sleep paralysis (the feeling while asleep that one cannot move). The all-night sleep records of these cases show that their night's sleep usually begins with a REM period rather than with two hours of nonREM sleep preceding the first REM period as in the normal person.[3] The vivid mentation which accompanies this sleep onset REM period explains the occurrence of the hypnogogic hallucinations. Extended polygraphic recordings during the day indicate that the sleep attacks, the occurrence of sleep paralysis, and perhaps also the attacks of cataplexy are all sudden onsets of REM sleep.[4] These symptoms usually begin in adolescence and are often associated with other psychological disorders. This specific entity has been called essential, primary, or "true" narcolepsy.[5] Those individuals with sleep attacks secondary to carbon dioxide narcosis or other systemic or brain disease and those cases of sleepy individuals without other symptoms have nonREM sleep during their attacks and a normal sleep pattern at night. Many refer to this group of disorders as secondary or pseudonarcolepsy.

Sleep studies using the division of sleep into REM and nonREM categories have also produced a more rational approach to the prescription of sleep producing drugs. Most sleep producing drugs such as the barbiturates decrease the percentage of the night's sleep spent in the REM stage, decreasing the REM percentage from around 25 percent down to 20 or 15 percent. However, if these drugs are administered chronically, after a few nights the REM percentage creeps back up to the pretreatment level. When the drugs are abruptly withdrawn, REM percentage rises above the baseline value; this is the so-called REM rebound. Some have taken the view that the ability of sleep producing drugs to decrease the amount of REM sleep is the direct physiological drug action which produces sleep with less emotional mentation. Others have thought that this effect and the REM rebound on withdrawal are undesirable side-effects. Preliminary studies have reported that chloral hydrate and flurazepam lack REM suppression properties and the subsequent advertisements have indicated that the manufacturers of these medications consider REM suppression an undesirable side-effect. However, many sleep researchers in their drug studies have not observed standard pharmacological rules such as double-blind administration of drug and placebo, and it is probably too early in the growth of this field to emphasize

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slight differences from one hypnotic to another.[6] The general effect of sleep drugs, however, is clear and the clinical correlation is obvious. One cannot expect to administer sleep producing drugs indefinitely; one must expect vivid mentation and perhaps insomnia during the first few days of withdrawal after chronic use of a hypnotic. While fine for the night before surgery, sleep drugs should seldom be used chronically.

Sleep research has examined a number of diverse clinical problems. All night EEG studies have shown, for example, that both patients with nocturnal angina pectoris and patients with migraine headaches awaken with pain from REM sleep much more often than they awaken with pain from nonREM sleep.[7, 8] Patients with hypertension have marked excursions of blood pressure, frequently to high levels, during both nonREM and REM sleep.[9] Drugs which decrease REM percentage have been recommended in crisis situations in cardiac patients, but as previously described one cannot expect to continue REM deprivation more than a few days, and these sleep drugs must be withdrawn slowly to minimize REM rebound. Similarly these drugs have been used to decrease nocturnal eye movements in ophthalmologic patients who have undergone eye surgery.[10] Duodenal ulcer patients have increased gastric acid secretion during REM periods but not during nonREM sleep.[11] Like angina, migraine, and hypertensive attacks, this increased acid secretion, which does not occur in normal persons, may be related to the emotional content of REM mentation. On the other hand enuresis, sleep talking, and sleep walking occur during nonREM sleep, particularly in nonREM sleep stage 4, and these disorders may be related to inefficient arousal mechanisms.[12] In epileptic patients, seizure discharges often are more frequent during nonREM sleep than during wakefulness, but almost always decrease or even disappear during REM sleep.[13] This disappearance of epileptiform activity during REM occurs in subcortical sites as well as in the scalp EEG and is the case in petit mal, grand mal, and psychomotor seizures. In 14 and 6 positive spike disorder, the EEG abnormality becomes more frequent during REM than during nonREM sleep and a few temporal lobe epileptics have been reported with seizures during REM sleep associated with the appearance of the patient's aura in ongoing sleep mentation.[14] Asthma attacks can begin in any stage of sleep but are somewhat less frequent in stage 4 than in other nonREM substages or in REM sleep.[15]

Rather than examine in which stage of sleep an attack or exacerbation of disease occurs, one can look at the way different diseases affect sleep patterns. The first disorder to be studied in this manner was chronic schizophrenia since a number of investigators had postulated a relationship between the thought disorder of schizophrenia and the fantasy nature of REM mentation. Multiple studies have shown, however, that the REM percentage in this disorder is probably within normal limits.[16] In chronic alcoholism, on the other hand, REM percentage is increased during alcohol withdrawal.[17] In fact in the period between the cessation of drinking and the onset of the complete delirium tremens syndrome, REM percentage reaches very high levels, up to 100 percent of sleep in some cases.[18] Patients with arteriosclerotic brain disease have a decreased amount of REM sleep and awakenings from REM often result in disorientation.[19] Patients with many types of mental retardation including phenylketonuria and homocystinuria have a decreased amount of REM sleep.[20] Several disorders, including hypothyroidism, epilepsy, depression, and schizophrenia have been associated with a decreased amount of stage 4 sleep increasing toward normal with the remission or treatment of the disease. Since normal people show less stage 4 on the first night in the sleep laboratory than on later nights, decreased stage 4 in these states could be more related to acclimatization to the laboratory than to sleep pathophysiology. During the course of pregnancy, women suffer a marked decrease in stage 4 sleep, even a complete disappearance[21] and there is some slight evidence that the sleep cycles of the mother and the fetus might be interrelated, presumably by unknown humoral mechanisms.[22]

Some limited work has been performed relating eye movement disorders during wakefulness to abnormalities of the eye movements during REM sleep. Patients with the inability to look to one side, either due to a lesion in the opposite hemisphere or in the pontine gaze center, do not have movements to that side during REM sleep.[23] Patients with congenital nystagmus have a disappearance of the nystagmoid eye movements as they enter nonREM sleep, but the nystagmus reappears during REM sleep.[24] Blind persons, even those blind since birth, have eye movements during REM sleep.[25] In addition, the occurrence of penile erection during REM sleep has been used to differentiate psychologic from organic causes of an inability to obtain or maintain an erection during wakefulness.[26]

In summary, sleep studies using the division of sleep into REM and nonREM categories have produced many small advances in clinical knowledge. Better understanding of the disorder known as narcolepsy and a more rational approach to the use of sleep producing medications serve as two areas where sleep research has made important clinical contributions.

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Venereal Disease Detection in the Female Patient

By F. J. Hofmeister, MD, Milwaukee, Wisconsin

While the prime objective of today's society seems to focus on youth and drug dependence, venereal disease is now the nation's number one reported communicable disease. Over 50% occurs in youth between the ages of 15 and 19. Obstetrical services report an incidence of 8 to 10% in pregnant women. It is practically in an epidemic state. Further increase may require drastic measures. Over 2,000,000 new cases of gonorrhea are treated yearly in the United States. Syphilis has increased six-fold. The female is often the silent carrier.

Are you fulfilling your obligation to your patient, the unborn fetus, your community? Are you conscious of your obligation to all mankind? What should you be doing?

1. A gonorrhea culture on every female with a troublesome discharge.

2. A gonorrhea culture and serology on every new female patient.

3. A routine Papanicolaou smear, gonorrhea culture and serology as well as a hemagglutination inhibiting test* (HI or HAI), blood type and Rh at every premarital examination.

4. A gonorrhea culture and serology with every new obstetrical case. Naturally, a type and Rh and an HI if not previously done and a Papanicolaou smear if it has not been done within one year.

5. During pregnancy, if an irritating discharge is present, rule out trichomonas and monilial but don't forget to culture for gonorrhea.

6. Repeat gonorrhea culture and serology in the last month of pregnancy.

Remember—The vaginal smear is unsatisfactory for effective detection.

Remember—Transport medium is available through your state laboratory for use on your patients.

Remember—Venereal disease does not respect anyone in today's society. It occurs among the affluent as well as the poor. □

* If above 1:40, it indicates immunity. If less than 1:8, patient should be given vaccine but must avoid becoming pregnant for a period of at least two months and preferably three months.

Diabetic Screening in Gynecology and Obstetrics

By F. J. Hofmeister, MD,
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In 1962, when Carrington and Messick[1] again emphasized the diabetogenic effects of pregnancy, many obstetricians were reminded of the seriousness of this phenomenon and the importance to both mother and infant of the obstetrician being aware of its existence. Some previously puzzling perinatal deaths were explained by the discovery of latent diabetes in the pregnant woman. The authors suggested doing a two-hour postprandial blood glucose determination as part of the evaluation of the pregnant woman and a glucose tolerance test on each patient whose history suggested a genetic predisposition to diabetes.

Interest generated by the Carrington publication was further enhanced by an experience with one of our patients, age 26, Gravida III, Para II. Routine laboratory examinations, blood counts, and urinalyses were always normal with the exception of a single episode of melituria. The third infant was delivered without incidence. The patient, not one of the most conscientious and cooperative, was next seen as a hospital patient three months postpartum. She had been hospitalized by her internist for "weak spells" and a "fainting episode." Her internist requested consultation to evaluate a severe vaginitis. This patient had developed a severe, brittle diabetes following the third infant. The "fainting episode" was a diabetic coma. With exacting diabetic management, she has since delivered a fourth infant. Retrospectively, many of her problems could have been prevented and the potential existence of her diabetes ascertained by routine antepartum diabetic screening or even diabetic screening when the single episode of melituria occurred.

You and I no longer have the right to ignore melituria during pregnancy and consider it a frequently occurring variation of the normal pregnancy state or as lactosuria.

We believe that diabetes is so great a hazard to mothers and their infants that a program, here reported, has been designed for diabetes detection.

Our study group included 372 obstetrical patients at Lutheran Hospital of Milwaukee. The patients averaged 25 years of age with a range of 19 to 39 years. All patients were asked to prepare for the test by eating a high carbohydrate diet for three days prior to the test. On the day of the "Diabetes Screening Test" (DST) the fasting patient was given the equivalent of 75 grams of glucose in a cola flavored carbonated drink (Western-Reserve formula). Venous blood was drawn one hour and two hours after the test meal. Serum glucose was determined from these samples using either the Nelson–Somogyi or autoanalyzer methods. Urine taken at the time blood was drawn was analyzed for glucose content. Women in whom there was a family history of diabetes and those women who had an abnormal DST were given a four-hour glucose tolerance test after similar preparation.

Normal values for fasting and postprandial serum glucose in our laboratory are shown in Table 1. The normal three-hour value in our laboratory has not been established.

In Table 2, 83 of the 372 obstetrical patients (22.3%) had abnormally elevated postprandial glucose at either one hour or two hours after the test meal. In only three patients was this finding anticipated by history. Three patients exhibited melituria. Patients with borderline hyperglycemia were closely observed during their pregnancy and tested again eight weeks after delivery. Those with significant hyperglycemia were referred for further observation and treatment. It is interesting to speculate how this knowledge extrapolated to a large obstetrical service could have affected perinatal mortality. At Lutheran Hospital of Milwaukee every obstetrical admission has her Rh and chest x-ray film report recorded as part of her admission requirements. These have been done during the antepartum period. Of the 1,468 patients delivered in 1968, less than 10% have had a diabetic screening and the results recorded. If it had been required, it is reasonable to believe that 327 instead of 83 would have been positive to diabetic screening.

Our statistics have value in two areas. We have found the incidence of postprandial hyperglycemia higher than previously suspected. However, we believe having been alerted to better management of

Table 1—*Normal blood glucose values*

Fasting	90–120 mg 100 ml
1 hr. postprandial	<185 mg 100 ml
2 hr. postprandial	<140 mg 100 ml
3 hr.	undetermined
4 hr. postprandial	90–120 mg 100 ml

Table 2—*Obstetrical patients tested*

Number of patients tested	372
Average age 25	Age 19 to 39
Positive diabetic screening	83–22.3%
Positive history or melituria	8
Unsuspected, no symptoms or melituria	89–96.3%

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TABLE 3—*Gynecologic patients tested*

Number of patients	1248
Average age, 54	Age 25 to 86
Positive to diabetic screening	164, 13.1%
Positive history or melituria	8
Totally unsuspected	156, 12.5%
Ratio of unsuspected to those detected	156 of 164 95.1%

TABLE 4—*Blood sugar range in unsuspected patients*

46 patients had DST >	200 mg 100 ml in 1 hour
Range varied from	440 mg 100 ml in 1 hour
to	486 mg 100 ml in 2 hours

the distressed infant born of the diabetic or potentially diabetic woman is of even greater importance. The necessity of being alert to the fact that the distressed, hypoxic newborn infant may be the victim not only of acidosis but of hypoglycemia secondary to unsuspected maternal hyperglycemia, has repeatedly been emphasized by Dr. J. P. Grausz of the Newborn Intensive Care Unit at the Medical College of Wisconsin, Milwaukee, and Dr. Stanley Graven of the Newborn Institute of the University of Wisconsin Medical School, Madison. Prompt, intelligent use of intravenous 10% glucose and 10% sodium bicarbonate could immediately eliminate the tragedy. The use of one alone could be a failure. Dextrostix® available in the delivery room and nursery may add in establishing a diagnosis. It is apparent that antepartum maternal glucose levels, as well as the Rh, must be made a part of every delivery room pre-admission record.

The unusually high incidence of postprandial hyperglycemia in obstetrical patients prompted us to extend the detection program to the gynecology group.

In this series (Table 3), all new patients over 40 years of age and all patients scheduled for operation were given the DST after proper preparation. This group of women ranged from 25 to 86 years of age with an average age of 54 years. Thirteen percent, or 164, of 1,248 patients examined exhibited postprandial hyperglycemia. Only 8 patients of the 164 had shown either melituria prior to the test or a family history of diabetes. Thus, about twelve percent of the series had asymptomatic and unsuspected postprandial hyperglycemia. Again, the incidence of postprandial hyperglycemia was higher than suspected.

It is interesting to note that blood sugar levels in the unsuspected group were significantly high (Table 4). Forty-six (46) patients had a hyperglycemia over 200 mg/100 ml at the one-hour test. There was no melituria. The highest of these in the unsuspected group ranged from 440 mg/100 ml at one hour to 486/100 ml in two hours. We have found the two-hour postprandial serum glucose test most sensitive to postprandial hyperglycemia. Second only to the two-hour postprandial serum glucose is the one-hour postprandial serum glucose. Either of these are more sensitive to glucose intolerance than the fasting serum glucose determination. However, three cautions are advised. Proper dietary preparation of the patient greatly reduces the incidence of false positive results. Secondly, patients on chlorothiazide therapy may show altered glucose tolerance unrelated to pancreatic islet function. Finally, the patient who is on oral contraceptive medication[2] may exhibit the same glucose intolerance as manifested in pregnancy.

Conclusion. To be ever alert to the latent diabetic, we strongly advise the "Diabetes Screening Test" (DST) for every pregnant woman, every gynecological patient over 40 years of age, and every patient who is being prepared for operation. Consideration must be given to the use of the diabetic screening tests when monitoring the patient who has been on oral contraceptives for prolonged periods of time and probably should be a part of her physical evaluation before starting her initial pill.

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Studies for Hemolysis Following Aortic Homograft Surgery

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J Thorac Cardiovasc Surg 59: 668–672 (May) 1970

Aortic homograft valves have distinct advantages over prosthetic valves. For example, anticoagulation is not required after aortic homograft insertion. If the incidence of hemolysis is significantly less than with prosthetic and heterograft valves, this would be an additional important advantage.

We found that after aortic valve homograft surgery there was no evidence of hemolysis in 25 of 27 patients studied. The cause of the mild hemolysis in two of the patients is unknown; however, a defective aortic homograft was suspected in one of the cases.

We believe patients undergoing valve surgery should be screened postoperatively for hemolysis. First, it may serve as a warning that the valve is malfunctioning and occasionally this has led to reexploration and replacement of a defective valve. Second, iron-deficient anemia may develop as a result of increased urinary losses of iron and further complicate the hematologic disorder.

We concluded that an adequately functioning aortic homograft does not produce hemolysis. □

SERUM HEPATITIS

SPECIAL TO THE JOURNAL

Information on Hepatitis Associated Antigen Testing

By Arthur L. Van Duser, MD, Madison, Wisconsin

AUSTRALIAN ANTIGEN was discovered by Baruch S. Blumberg, MD and workers, in 1963. Subsequent studies established a hepatitis association, and the consensus is that the antigen is serum but not infectious hepatitis associated. Studies suggest that hepatitis associated antigen (HAA) is transmissable by parenteral, oral, and possibly respiratory routes. It is rare in the general adult American population, 0.1 percent, but relatively common, about 2 percent, in commercial donors. For this reason, some countries and certain major cities refrain from using commercial donor blood. On repeat testing HAA usually is demonstrable early in acute serum hepatitis cases, and it has been found in some active chronic hepatitis. HAA tends to be transient but can persist for years. Failure to detect HAA does not rule out serum hepatitis.

Approximately 6,200,000 transfusion units are collected in the United States each year: American Red Cross, 3,200,000; commercial banks, 1,500,000, and other voluntary banks or facilities, 1,500,000. In addition, perhaps 1,800,000 commercial blood units are procured for plasmapheresis and blood components by pharmaceutical companies. It is estimated that transfusions cause 150,000 cases of hepatitis each year, of which 30,000 are serious and result in 1,500 to 3,000 deaths. The risk of developing hepatitis from multiple commercial blood transfusions is particuarly high. A recent report on open heart surgery patients, averaging 20 blood transfusions, showed an icteric and anicteric hepatitis rate of 51 percent within six months.

A number of laboratory tests have been devised to detect HAA and several more are in developmental stages. The currently more practical agar gel diffusion and counterelectrophoresis tests have a capability of detecting about 25 to 30 percent of the transfusion units containing HAA. Despite this, low sensitivity routine testing would make a significant reduction in serum hepatitis morbidity and mortality. As testing methodology improves, HAA detection rates are expected to increase sharply.

In addition to the health hazard to transfused patients, blood banks, hospitals and medical care personnel have been subjected to lawsuits as a result of hospital-acquired hepatitis. Some courts have made awards based not on negligence but on the premise that blood and other tissues are products for sale and carry an implied warranty liability. Thus in the legal arena, blood banks, hospitals, and medical care providers may be held liable by negligence or by implied warranty, even though for the latter neither adequate knowledge nor technology exists to completely prevent transfusion hepatitis. Currently the majority of states are in the process of enacting or amending legislation to define the provision of blood and other tissues as a service and not a sale, and to relieve providers from liability except for negligence.

In recent months, a committee of the National Academy of Sciences—National Research Council recommended that as soon as methodologic, supply, and reagent licensure problems are solved, all blood banks should begin HAA testing. The American Association of Blood Banks has advised its members to give immediate attention to routine HAA testing of all drawn blood. In April, the Division of Biological Standards of the National Institutes of Health recommended that as soon as supplies permit, whole blood and plasma for fractionation should be tested for HAA, and that positive-reaction blood should not be issued for transfusion or the preparation of components or fractions. The Division of Biological Standards has licensed Spectra Biologicals and Abbott Laboratories to manufacture the reagent, Hepatitis Associated Antibody. The reagent, other supplies, and complete kits for testing now are available to laboratories from a number of commercial sources.

New York City has required HAA testing of transfusion blood since January 1 of this year. Other cities and some states are considering mandatory testing legislation. The American Red Cross recently began testing of blood drawn by their units. Many community banks have initiated testing programs.

In Wisconsin an ad hoc HAA Laboratory Testing Committee with appropriate hospital, medical, blood bank, laboratory and government agency representation have held two meetings relative to transfusion hepatitis problems. Committee accord or consensus appears to exist as follows:

1. All transfusion blood should be subjected to HAA testing, unless an emergency makes testing impossible.
2. Blood banks and blood drawing facilities should maintain or participate in a registry of HAA carriers, as determined by donor testing, epidemiology or history.
3. Established carriers of HAA should be informed of that finding and instructed not to donate blood.

Doctor Van Duser is Chief, Section of Laboratory Evaluation, Bureau of Preventable Diseases, State Department of Health and Social Services.

4. Positive-reaction blood should not be used for transfusion or component fractions.
5. The use of commercial donors should be discouraged, and a more adequate and safer blood supply procured through greater support of nonprofit volunteer systems.
6. Communities should redetermine their blood service programs in light of the need for HAA testing.
7. For HAA testing, laboratories must maintain quality control procedures to assure proficiency and to minimize the risk of personnel exposure to infectious materials. Small volume banks should consider procurement of total blood needs from larger units.
8. Training in HAA testing should be initiated at local and central levels for laboratory personnel.
9. A voluntary participation proficiency testing program for HAA should be made available to laboratories by the State Division of Health.
10. Support should be given to pending Wisconsin legislation that defines the provision of blood and other tissues as a service, and removes liability therefrom, except for negligence or willful misconduct.
11. Avenues to compensate transfusion hepatitis patients by specific insurance coverage rather than by lawsuit procedure should be investigated.
12. Good transfusion practices in donor selection and examination, and in the use of appropriate patient consent forms, should be adhered to. □

Backward Transmission of Left Atrial V Wave and Premature Pulmonary Valve Closure

D. A. SPRING, MD, and G. G. ROWE, MD, University of Wisconsin Medical School, Madison, Wis: *Amer Heart J* 81:327–334 (Mar) 1971

This communication describes the finding of premature closure of the pulmonary valve in subjects with severe mitral insufficiency who exhibit a marked late regurgitant wave in the pulmonary artery pressure pulse. Analysis of the pressure curves from five such subjects revealed: (1) a high left atrial "V" wave which exceeded the right ventricular and pulmonary arterial systolic pressure; (2) reversal of the pressure gradient between right ventricle and pulmonary artery so that the pulmonary artery mean pressure exceeded right ventricular systolic mean pressure; (3) a sharply inscribed late pressure peak in the pulmonary artery which equalled or exceeded the right ventricular systolic peak; (4) during pressure recording the late pressure wave was "cut off" by the pulmonary valve as the catheter was withdrawn from the pulmonary artery to the right ventricle.

The reversal of the mean pressure relationship between pulmonary artery and right ventricle coupled with a continuing rise in the pulmonary artery pressure after both ventricles had stopped contracting supports the concept that regurgitation from the left ventricle may cause reversal of flow through the pulmonary circuit resulting in premature closure of the pulmonary valve and further diastolic elevation of the pulmonary artery pressure.

In two subjects the timing and morphology of the late pressure wave clearly suggested that the pulmonary valve was being closed during right ventricular systole before the onset of isometric relaxation. A second group of five subjects with severe mitral insufficiency who had closely similar peak V wave pressures in the left atrium but no regurgitant pressure waves in the pulmonary artery was compared with the premature closure group and found to have no significant differences in mean pulmonary artery pressure or pulmonary resistance. The difference in pulmonary artery pressure pulse findings between the two groups was discussed in terms of the respective roles played by the pulmonary arteriolar resistance, the compliance of the left atrium and pulmonary vasculature, the state of left ventricular function, and the force and/or volume of mitral regurgitation.

It is suggested that early pulmonary valve closure occurs only in the presence of extremely severe mitral insufficiency. □

NEW DRUG RESEARCH

Phentolamine: Showed significant improvement in all the measured parameters of pulmonary function in patients with chronic pulmonary emphysema. The drug was administered by inhalation. By Dr. Lawrence Gould and Mary Delicto, Veterans Administration Hospital, Bronx, N.Y.—AMERICAN DRUGGIST, October 19, 1970 □

R054023: Proved to be quite effective in the control of minor motor seizures in 20 patients. However, the drug did not reduce major motor seizures. The drug, which is manufactured by Hoffmann-LaRoche was found to be safe from the toxicity standpoint. By Dr. H. Hooshmand, Richmond, Va. —AMERICAN DRUGGIST, Jan. 11, 1971 □

Colestipol: Lowered serum cholesterol levels in hyperlipidemic males by approximately 20% for as long as 36 weeks when compared with a placebo control. The drug was administered in a dose of 4 gm to 5 gm 3 times a day. By Dr. T. M. Parkinson and associates, Upjohn.—AMERICAN DRUGGIST, Jan. 11, 1971 □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Professor of Clinical Pharmacology, Medical College of Wisconsin, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Retinal Detachment

By Matthew D. Davis, MD, Madison, Wisconsin

"FLOATERS," I.E., SPECKS, STREAKS, or cobwebs, which appear to the patient to drift across his field of vision, represent one of the most common of all visual complaints. If the floaters are faint, lead to no impairment of visual acuity, have been present for many months or years and did not begin suddenly, they are usually of little importance, signifying merely the presence of more or less normal opacities in the vitreous. If, on the other hand, the onset of the floaters was sudden, they probably signify *posterior vitreous detachment with collapse,* an aging change which, although not in itself serious, not infrequently leads to formation of *retinal tears* and subsequent *retinal detachment.*

Since early recognition of retinal detachment, prior to involvement of the macula, is essential if normal vision is to be preserved, the possibility of *retinal detachment should be foremost in the physician's mind whenever the patient reports the sudden onset of floaters.*

The normal vitreous in youth is a more or less homogenous transparent gel made up of a wide-meshed, three-dimensional network of collagen fibers, the interspaces of which are filled with polymerized hyaluronic acid molecules, water, and electrolytes. With increasing age the vitreous becomes less homogenous, less solid; and during the sixth or seventh decade, contraction and collapse of the vitreous framework is very common. The vitreous then becomes divided into a more solid portion which sinks down to the inferior portion of the vitreous cavity and a completely liquid portion which remains superiorly. Normally the vitreous is firmly adherent to the retina at its junction with the ciliary body (the ora serrata) and to the adjacent posterior part of the ciliary body itself. The vitreous contains more collagen and is more solid in this area (the "base of the vitreous"). A less firm adhesion exists between vitreous and retina at the disc and macula, with a weak union in all other areas.

In normal eyes, the vitreous framework is able to pull away from the retina at the time of vitreous collapse. A ring-shaped thickening in the posterior vitreous surface, representing the previous adhesion between the vitreous and the optic disc, often can be seen ophthalmoscopically floating a short distance in front of the retina. The shadows cast upon the retina by this or other vitreous opacities are the usual cause of the patient's symptom of floaters. They are most noticeable when gaze is directed to a bright area such as the sky, a white wall or a piece of paper and are rarely sufficiently dense to impair visual acuity. The vitreous framework remains adherent to the retina at and just posterior to the ora serrata, and as it surges around in the vitreous cavity with ocular movements after vitreous collapse it may stimulate the retina by bumping it or tugging on it, thus leading to the subjective symptom of flashes of light.

In some eyes abnormal adhesions are present between vitreous and retina, usually in the periphery of the upper one-half of the fundus between the equator and the ora serrata. When vitreous collapse and contraction occur in such eyes, the vitreo-retinal adhesions may be stronger than the retina itself and traction exerted by the vitreous on the retina frequently leads to tearing of the retina. Probably about 15 percent of eyes with symptomatic posterior vitreous detachment actually have one or more retinal tears.[1] Of these eyes with tears, perhaps one-third to one-half go on to clinical retinal detachment.[2]

Continuing tugging of the vitreous framework on the flap of the retinal tear is probably the most important factor promoting retinal detachment. As the retina is pulled inwards, the fluid portion of the vitreous flows through the tear, accumulating between the retina and the pigment epithelium and re-establishing a space comparable to the cavity of the optic vesicle, which was obliterated in embryonic life when the vesicle "invaginated" to form the optic cup. If the flap of the tear loses its connection with the retina, becoming completely avulsed (then termed an operculum), traction is relieved and subsequent retinal detachment is less likely. If retinal

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detachment does not occur within three to six months following tear formation, the likelihood of its occurrence later drops from 30 to 50 percent to perhaps 5 to 10 percent or less.

Unfortunately, many retinal tears will be overlooked unless the peripheral fundus is examined with painstaking care through a fully dilated pupil, preferably with *binocular indirect ophthalmoscopy and scleral depression*. This is a relatively new and difficult technique which has not yet been adopted by all ophthalmologists. Ideally, every patient reporting the sudden onset of "floaters" should be examined with this method, but if this is not feasible, it should be assumed that a retinal tear may be present and the patient should be properly instructed in regard to the possibility of subsequent retinal detachment. Such instruction should emphasize *three* items:

(1) Floaters and/or light flashes are symptoms common to *both* posterior vitreous detachment (with or without retinal tear formation) and retinal detachment. No differentiation between these possibilities can be made on the basis of these symptoms alone.

(2) Retinal detachment which spreads to involve the macula nearly always results in permanent impairment of visual acuity, even after successful surgical reattachment.

(3) Retinal detachment usually develops slowly enough so that the properly informed patient will become aware of it before the macula is involved, *if* he becomes and remains aware of his *peripheral visual field*. The physician should therefore test the patient's confrontation field, teach him to test his own field and advise daily repetition of this self-testing and immediate notification of the physician should any defect develop. Many patients require *two* visits to the physician before they learn the three essentials of proper visual field testing:

   (a) Occlusion of one eye while testing the other.

   (b) Maintenance of fixation straight ahead (looking at his own eye in a mirror is convenient).

   (c) Learning the normal extent of the field in all four quadrants as a base line against which to judge future loss.

It is of utmost importance for the patient to realize that a peripheral field defect probably means beginning retinal detachment and to understand that he must be reexamined *immediately* upon recognizing field loss.

Since vitreoretinal adhesions are particularly common along retinal vessels in the equatorial region, retinal tear formation frequently involves one or more vessels, leading to *vitreous hemorrhage*. Blood suspended in the vitreous cavity is seen by the patient as "floaters" *generally marked enough to reduce visual acuity*. Proper emphasis has not been placed on retinal tear formation as *the single most common cause of vitreous hemorrhage* in otherwise apparently normal eyes, that is, eyes without obvious neovascular retinopathy or recent severe trauma. Consequently, the physician's attention often is focused on a search for some systemic causal condition, such as diabetes, vascular hypertension, a blood dyscrasia, and the like, when actually the explanation of the vitreous hemorrhage is to be found in the eye itself.

Ophthalmoscopic visualization of the tear may be made difficult by the presence of vitreous hemorrhage and failure to find a tear, therefore, by no means rules out its presence. Only occasionally does posterior vitreous detachment lead to vitreous hemorrhage *without* a full thickness retinal tear,[1] so that all eyes with vitreous hemorrhage without an obvious cause, such as proliferative diabetic retinopathy, should be considered to harbor a retinal tear until proven otherwise by careful binocular indirect ophthalmoscopy with scleral depression, repeated, if necessary, after clearing of the vitreous hemorrhage. In the meantime, the patient should be given the usual explanation regarding retinal detachment and instructions in visual field testing. The prognosis, however, must be more guarded, since in the presence of vitreous hemorrhage, the likelihood of a retinal tear increases to greater than 50 percent.

The treatment of retinal tears and retinal detachment has impoved greatly over the past 15 years, chiefly because of improved ophthalmoscopy and the development of the scleral buckling operations. Treatment consists of closure of the retinal breaks, generally accomplished by producing adhesions between the retina surrounding the tear and the underlying pigment epithelium and choroid. This involves creation of an inflammatory reaction in the choroid and pigment epithelium and establishment of contact between the retina and pigment epithelium in this area until a firm scar is formed. The inflammatory reaction is usually produced either by heat (diathermy, photocoagulation) or freezing. Theoretically, contact between retina and pigment epithelium might be secured by either moving the retina to the pigment epithelium or by pushing the pigment epithelium in against the retina. The former would seem preferable, but in practice can be accomplished only in a minority of cases and then only by complete immobilization of the patient (strict bed rest) and his eyes (binocular patching) for a period of 10 to 20 days, an ordeal unpleasant at best and in older patients distinctly hazardous (thrombophlebitis, pulmonary embolism, hypostatic pneumonia, mental confusion, disorientation, and depression).

Since most retinal tears occur near the equator of the globe, the wall of the eye (sclera, choroid and pigment epithelium) may be pushed inwards against the retina without producing clinically objectional distortion of the optical characteristics of the eye.

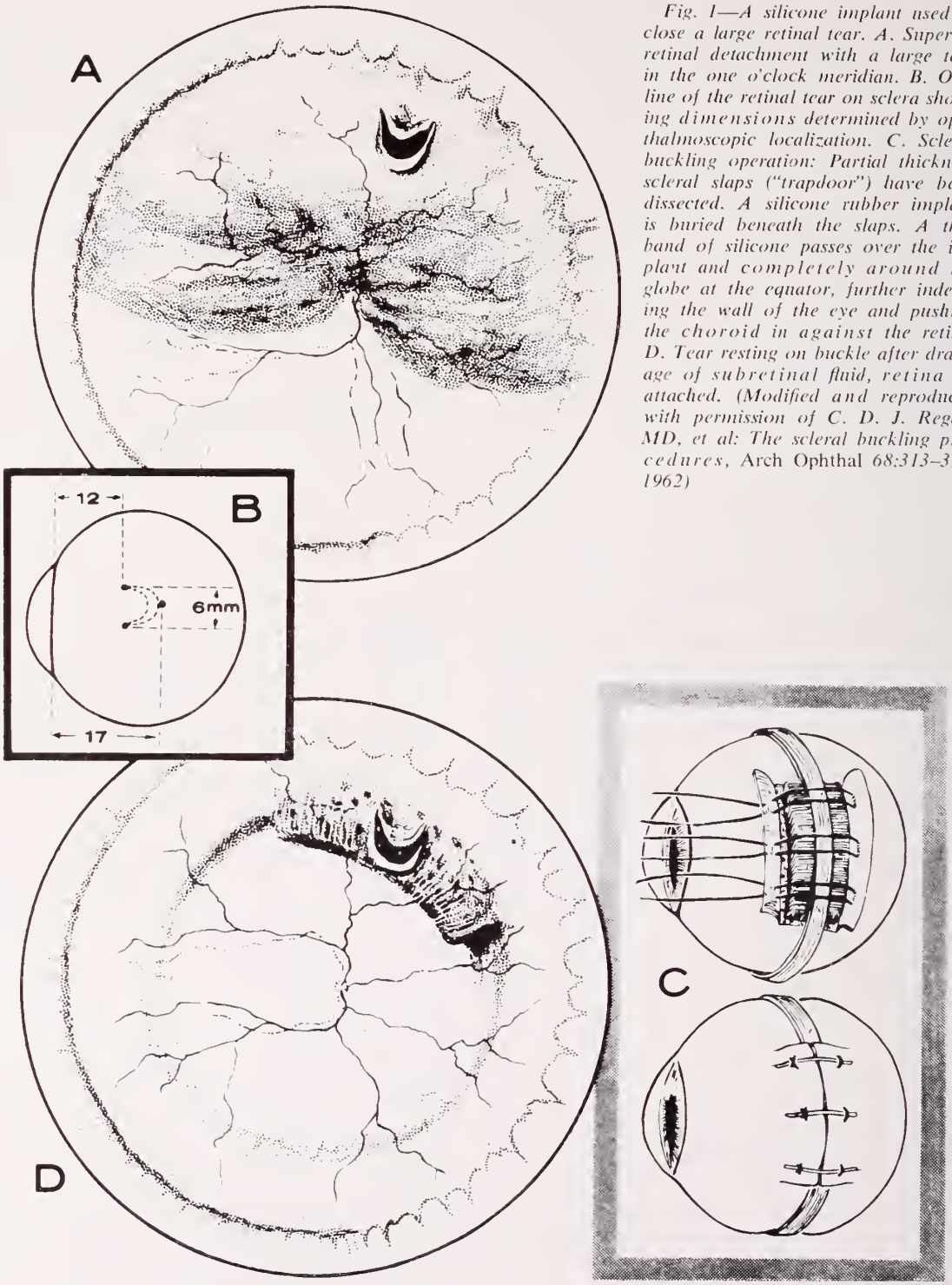

Fig. 1—A silicone implant used to close a large retinal tear. A. Superior retinal detachment with a large tear in the one o'clock meridian. B. Outline of the retinal tear on sclera showing dimensions determined by ophthalmoscopic localization. C. Scleral buckling operation: Partial thickness scleral slaps ("trapdoor") have been dissected. A silicone rubber implant is buried beneath the slaps. A thin band of silicone passes over the implant and completely around the globe at the equator, further indenting the wall of the eye and pushing the choroid in against the retina. D. Tear resting on buckle after drainage of subretinal fluid, retina reattached. (Modified and reproduced with permission of C. D. J. Regan, MD, et al: The scleral buckling procedures, Arch Ophthal *68:313–328, 1962)*

This is generally done by suturing a piece of biologically inert plastic (silicone) against the external surface of the sclera or beneath its external layers, in such a way as to *indent* the eye at the site of the retinal tear, producing a *ridge* internally against which the retina comes to rest. Fortunately the ridge need be created only at the site of the retinal tears, for once they are closed and fluid from the vitreous cavity can no longer circulate through them into the subretinal space, the subretinal fluid is absorbed into the choroidal circulation and the retina becomes "reattached."

A more pronounced ridge may be produced by allowing the plastic to encircle the eye at its equator, fastening the ends of the plastic together, just as one would fasten a belt around the waist. Because the sclera is *buckled* inwards, these procedures are termed "scleral buckling operations" (Fig 1). The greater the extent of vitreous contraction, the more pronounced ("higher") the ridge ("buckle") re-

quired to bring the pigment epithelium into contact with the retina. Neither bed rest nor binocular patching are required following the scleral buckling procedures and the overall "success rate," i.e., the rate of anatomic reattachment of the retina, has been improved by them from roughly 50 percent to 90 percent. Although these procedures are tedious, generally requiring from two to four hours, they can easily be carried out under local anesthesia with little risk to the patient. This is fortunate since the frequency of retinal detachment increases with advancing age.

Retinal tears without detachment may frequently be sealed by use of cryocoagulation or photocoagulation alone, without a buckling procedure. Such prophylactic treatment is indicated for recent symptomatic horseshoe tears, but is probably unnecessary if the flap of the tear has become an operculum or if six months or more have passed since the onset of symptoms suggesting posterior vitreous collapse.

The treatment of patients whose floaters are due to posterior vitreous detachment without retinal tears consists solely of explanation of their symptoms and reassurance. Usually within a year the symptoms become less prominent, perhaps because the vitreous framework moves more anteriorly so that opacities no longer cast discrete shadows on the retina, perhaps because the patient becomes accustomed to them.

Occasionally "floaters" are due neither to posterior vitreous detachment nor to vitreous hemorrhage, but rather to inflammation of the posterior part of the eye, i.e., chorioretinitis. In such cases the "floaters" are inflammatory cells and debris. Differential diagnosis usually lies between toxoplasmosis and "cause unknown," with only occasional cases in which some other organism, such as the tubercle bacillus or spirochete, is suspected.

Throughout the foregoing discussion, only retinal detachment due to a retinal hole or tear (rhegmatogenous retinal detachment) has been considered. There are, of course, other types of retinal detachment, such as the exudative detachment occasionally seen with uveitis, detachment secondary to malignant melanoma of the choroid, and detachment in severe vascular hypertension. In all of these cases the subretinal fluid originates in the choroid, not the vitreous cavity, and treatment is aimed at the underlying cause.

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2. Colyear BH and Pischel DK: Clinical tears in the retina without detachment, *Tr Pac Coast O & O Soc* 36: 185–219, 1955. □

Chronic Polymyositis and Myxovirus-like Inclusions

T. SATO et al (H. A. Peters, MD, University of Wisconsin Medical Center, Madison, Wis) *Arch Neurol* 24:409–418 (May) 1971

A 43-year-old man developed progressive weakness and wasting in both thighs over a two-year period during which he lost about 25 pounds of weight. His history included poliomyelitis without residuals in childhood. In 1951 he had a laparotomy for ileocecal intussusception. Because of recurrence he had had a bowel resection in 1958 without any evidence of tumor formation. Examination showed marked wasting of the quadriceps muscles and he could barely rise from a squat, and deep tendon reflexes were normal except for depressed knee jerks. Cranial nerves were intact. No fasciculations were observed. There was no skin rash.

Serum enzyme levels were elevated with a creatine phosphokinase of 9.8 units (normal 3.0), serum glutamic oxaloacetic transaminase 50 units, serum glutamic pyruvic transaminase 73 units (normal 8 to 40), serum albumin was 58%, a_1-globulin 4.4%, a_2-globulin 83%, β-globulin 12.2%, and γ-globulin 16.2%. Electromyography: action potentials of short duration and low amplitude in the quadriceps and deltoid muscles, a pattern consistent with myopathy. Increased resistance to insertion was also noted. There was no evidence of denervation.

Administration of 50 mg of prednisolone every other day for three months was without benefit.

Light and electron microscopy of muscle biopsies revealed intranuclear inclusions in the muscles resembling helical nucleo-protein of myxovirus type. Virological studies to demonstrate myxovirus revealed no cytopathic effects in African Green monkey kidney (Vero) and HEp-2 cell cultures inoculated with muscle biopsy homogenates over a two-month period. No cytopathy was observed in VERO cells inoculated periodically with culture medium from muscle biopsy cultures.

Fluorescent antisera did not reveal measles or mumps antigen in frozen biopsy, and low to moderate levels of serum antibodies against myxovirus were present in this case reported as well as in three other chronic polymyositis cases. These findings did not rule out a chronic myxovirus infection in chronic polymyositis and further virological studies with modified technics were recommended. The electron microscopic structures resembled the nucleocapsid of a myxovirus in muscle cells of a patient with chronic polymyositis previously reported by Chou in 1967 and 1968. □

Community-wide Risk Factor Screening Program

THE MADISON PROJECT

By William B. Parsons, Jr., MD
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SINCE 1949 PROSPECTIVE STUDIES in Framingham (Massachusetts), Albany (New York), Tecumseh (Michigan), and other locations have identified certain characteristics of individuals which are statistically correlated with risk of myocardial infarction, stroke, and other atherosclerotic disorders. An increasing body of evidence has incriminated these features, which are now known as *coronary risk factors*. The hypothesis that effective treatment of abnormal risk factors might reduce the risk of heart attack and related disorders has been substantiated by controlled studies in certain instances (notably hypertension and cigarette smoking) and is the subject of current large cooperative studies in other instances (serum lipids, physical exercise).

Recognizing the available evidence and consensus of informed opinion, the American Heart Association has recommended measurement of the factors which are most clearly associated with increased risk, followed by referral to physicians of any persons whose results exceed levels indicating at least a two-fold risk of heart attack. Several communities in the United States have conducted screening programs for limited numbers of persons over periods of weeks or months or have screened relatively small numbers in health fairs lasting days or weeks.

The first suggestion that a community-wide screening risk factor program be conducted in Madison arose from a discussion between two practicing internists,* following an evening of work on data from their own clinical investigation related to treatment of individual risk factors. They had discussed the identification and treatment of coronary risk factors at several staff meetings of their multispecialty clinic and had begun to plan a screening program for patients of that clinic, either on a single occasion or on a continuing basis. As they considered these plans, they decided that a larger, community-wide educational and screening program might be feasible. Dane County seemed an ideal location for such a pioneer effort, in view of its generally high standard of medical practice, relatively large number of physicians, and well-informed middle-class population.

In September 1968, they proposed to the Dane County Heart Unit that a community-wide program be planned, using the assembly-line processing technique they had envisioned for their clinic's private program. In the Unit's budget for the following year the Wisconsin Heart Association provided for an office and secretary, plus limited support for the initial phase of the program. As plans progressed in subsequent months, it became apparent that it would be wise to conduct a pilot project on a limited number of participants. Consequently, the previously mentioned clinic agreed to conduct its program in October 1969, using the same forms and methods designed for the community program contemplated for the following May.

Recognizing that cooperation of the medical community was essential to the entire program's success, the planners in October 1968 presented their preliminary concept of the program to the Board of Trustees of the Dane County Medical Society, who not only enthusiastically supported the program but also asked to be allowed to co-sponsor it. No definite financial support was pledged, and it was clearly understood that the Dane County Heart Unit would continue its primary role in all phases of planning.

GOALS

The stated goals of the program were:

1. Make the general public aware of the major coronary risk factors and the need for preventive measures against heart attacks and related blood vessel disorders.
2. Impress the medical profession and the general public with the desirability of assessing the coronary risk factors in apparently healthy individuals as well as in patients with recognizable coronary artery disease or other arterial disease.
3. Emphasize the optimistic, treatable aspects of the various risk factors and the likelihood of lessening risk by successful treatment.
4. Measure most of the major risk factors in a mass screening effort, offered to persons between 30 and 65 years of age.
5. Report findings of risk-factor screening to patients and their doctors, advising consultation with the physician at least for those persons with two-fold or greater risk of heart attack, as defined by the American Heart Association.
6. Recommend periodic examinations for complete evaluation of current health and consideration of preventive measures.
7. Mobilize community resources to make available to physicians certain facilities for the necessarily detailed, intensive attack on specific risk factors.
8. Assemble data on the prevalence of abnormalities in various risk factors for comparison with similar data assembled elsewhere as well as with possible follow-up observations in future years.

THE PILOT PROJECT

Beginning in September 1969, the Jackson Clinic issued invitations to many of its current patients to participate in a risk-factor screening program on Saturday morning, October 18. There was no publicity or other public announcement. An information brochure and return postcard were enclosed in a single month's cycle of billing and also mailed to patients with paid-up accounts from the previous three to four months, excluding children and those with Medicare numbers. Age limits for the pilot project, the same as established for the May 1970 program, were 30 to 65 years.

The exact number of eligible persons reached by the invitation cannot be clearly determined, but about 5,000 to 6,000 brochures were thus distributed. The geographic scope

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Presented at the 22nd Annual Meeting of the Wisconsin Heart Association, Memorial Union, University of Wisconsin, Madison, June 12, 1970.

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* John H. Morledge, MD and the author.

was different from the May 1970 program in that it was not limited to Dane County residents. Participants were asked to return a postcard indicating their intention to take part and specifying their preference of time interval, beginning at 8:30 a.m. and continuing at half-hour intervals until 12:30 p.m. Affirmative responses were received from 1,118 individuals, 45% of whom requested 8:30 a.m., undoubtedly because a sentence in the brochure had indicated that one additional test (serum triglycerides) could be done for anyone who chose to report in the fasting state.

The screening process consisted of:

1. Printing the patient's name and address and his physician's name and address on a mark-sense IBM form.

2. A brief medical interview regarding personal and family history of cardiovascular disease, cigarette smoking, and exercise habits.

3. Determinations of height and weight, blood pressure and pulse rate.

4. A blood sample, to be tested later for glucose, cholesterol, and (if fasting) triglycerides and lipoprotein electrophoresis.

5. Printed information regarding the program itself and the general management of risk factors.

Preliminary estimates stated that each participant would spend ten minutes or less from the beginning of the printing step until completion of the blood-drawing step, with each station in the line requiring two minutes or less. The blood-drawing station would average two to three minutes, but delays would be prevented by having more of these stations than the others. Because individuals moved from station to station as the steps were completed, it was estimated that one processing line could comfortably handle 120 patients or more in four hours. For the pilot project, ten such lines were set up, permitting about 1,200 participants to be screened in four hours, an average of 300 per hour.

Obviously the 449 participants who preferred to come at 8:30 could not all be handled at that time. For this reason a form letter was mailed to many of them explaining the situation and recommending that they come at specified later times (9:00, 9:30, 10:00, or 10:30).

On October 18, 930 patients underwent the screening process between 8:30 and 12:30. Whether many of the "no-shows" were disappointed patients who had received requests to defer their 8:30 visits cannot be determined. After about 10 o'clock five processing lines were closed because they were no longer needed. The schedule of ten minutes or less per patient was easily maintained, indicating that 1,200 participants could have been screened comfortably by the ten lines.

The pilot project proved the feasibility of the "assembly line" concept of screening, using physicians only in key roles (blood pressure determinations, blood drawing, and directors), with nurses, medical assistants, and office personnel capably performing all other tasks. Blood samples were picked up frequently and delivered to the laboratory, where ten technologists separated the serum for storage. Other staff for the pilot project included 23 physicians, 25 to 30 nurses, 12 medical assistants, and 37 office personnel.

Identifying information, together with results of the interview and physical measurements were stored in the computer. Laboratory results were added to each patient's file as they were completed. The computer was then programmed to print reports to be mailed to each participant and his designated physician, summarizing all the assembled information.

* Technicon Corporation, Tarrytown, N. Y.

COMMUNITY-WIDE RISK-FACTOR SCREENING PROGRAM (Heart Sunday)

A Medical Advisory Committee composed of internists and generalists had met once before the pilot project to approve its scope and general plan. Its members were kept informed during preparation of the community-wide program and met formally once again to work out final plans.

A Laboratory Advisory Committee, composed of the chief pathologists from each private hospital in Madison and University Hospitals, together with laboratory directors from the State Laboratory of Hygiene and the State of Wisconsin Division of Health, Bureau of Preventable Diseases, met several times to plan laboratory aspects of the community-wide program—rapid separation of blood on the screening day, storage of frozen serum, and performance of laboratory determinations. After consideration of several methods of obtaining chemical tests, arrangements were made for a leading manufacturer of automated equipment* to lend two cholesterol-triglyceride systems and two glucose systems for three to six months. A blood processing center with 20 or more centrifuges, each capable of spinning 96 tubes, was set up at the State Laboratory of Hygiene.

The Boards of Education in Madison and in seven towns in Dane County agreed to the use of their school gymnasiums or other suitable areas as screening centers. Sunday, May 3, was selected as the date on which county residents between 30 and 65 would be offered an opportunity to undergo the rapid screening process in any of 23 schools, 16 of them in Madison.

From several possible methods of financing the program, planners elected to charge each participant a fee of three dollars ($3.00). Medicaid agreed to pay the fee for its recipients. Because of the large number of volunteer workers, the cost could be kept to approximately three dollars per patient.

A Publicity Committee, led by the public relations director of a large local company, held a kick-off conference with news media representatives in mid-March. A public education program followed, beginning in April, consisting of newspaper releases, radio and TV spot announcements, and two 15-minute TV specials, all concerned with risk factors and the screening program. Announcements also encouraged medical and paramedical personnel to volunteer their services and urged eligible individuals to participate. As a short title, the American Heart Association permitted use of the name "Heart Sunday."

The key role of the private physician in follow-up care was emphasized throughout the publicity campaign, as was the co-sponsorship by the Dane County Medical Society. The optimistic, treatable aspects of risk-factor measurement and management were stressed, as in the frequently used statement, "Help your doctor to help you." Posters were placed in every pharmacy in the county, with a supply of double postcards, one to be returned to specify the participant's choice of screening center and his time preference, the other to be retained as a reminder of important instructions, including the suggestion regarding fasting. Each of Madison's two newspapers published a registration coupon on three occasions, usually accompanied by appropriate information.

Recruiting of personnel was carried out by mailings to members of the county medical society, its woman's auxiliary, District Nurses' Association, medical technologists, medical assistants, and lay groups such as service clubs. Staff nurses and student nurses in the hospitals were reached by nurse recruiters in each institution. Medical and paramedical personnel in clinic groups were reached by the Medical Advisory Committee members from each group. Each volunteer was asked to complete a commitment slip, pledging his services wherever needed on Heart Sunday, for four hours at the screening centers

or longer at the blood processing center (where lunch would be provided). When the early response was disappointing in all categories, telephone contacts were made with doctors and their wives by auxiliary members and the appeal for volunteers in the news media was intensified, permitting enlistment by telephone.

Original estimates of possible participants (from 70,000 or more in the eligible age group in the special 1968 census) ranged from 20,000 to more than 30,000 participants. Initial plans included enough lines in the schools to process more than 20,000 in a single morning, with provision for a second morning three weeks later if needed for a larger number. Three and a half weeks before May 3 the numbers of registrations for each center were tabulated, as were the volunteers then available. From the physicians and medical technologists who had volunteered, it was decided that about 110 assembly lines could be manned. These were allocated to the various schools according to the percentage of total participants who had thus far specified each school. As further registrations were received, these percentages remained remarkably stable and very few changes had to be made in assignment of personnel.

All volunteers understood that they would be expected to attend one of six briefing sessions, held in evenings during the last two weeks before Heart Sunday. These sessions explained the entire process and each worker's role. At that time each volunteer received a printed job description and his assignment to a school center. Despite unequivocal insistence on attendance at these meetings, a moderate number of volunteers failed to attend, resulting in their suboptimal performance on Heart Sunday. A shortage of volunteers made it impossible to exclude those who failed to attend briefing sessions; their assignments and job descriptions were mailed to them.

A total of 1,465 persons, including 285 physicians, 474 nurses, 240 medical technologists, 123 medical assistants, 103 physicians' wives, and 240 nonmedical volunteers offered their services and were assigned. Any late reassignment of personnel as needed was largely prevented by an unforeseen number of cancellations of their commitments by 116 volunteers, including 41 doctors, many of these in the last few days preceding the program. Several "no-shows" on Heart Sunday without prior notification were added, impairing to some degree the operation of some centers.

The numbers of screening lines at the schools varied from one at one school to fourteen at the largest center. The centers generally operated efficiently with few problems, none of which appeared to affect the accurate recording of the important information on the IBM forms. About two hours after the centers closed at 12:30 the processing center closed its operation, having separated and stored 12,379 serum specimens.

The screening day was judged a success by the staff, participants, and visiting observers. A critique was held about two weeks later with directors from some of the centers, summarizing and discussing comments returned on questionnaires by key personnel at all centers. The laboratory systems, received in mid-May, were promptly set up, standardized, and performing the lipid and glucose determinations, operated by two technologists.

Keypunching of the name and address data and machine reading of other data were completed late in July. Laboratory determinations on the 9,000-odd fasting samples were completed early in September and a moratorium was declared on further laboratory work until those results were stored in the computer. This process required about a month. In early October the first reports were mailed to participants and physicians.

After overcoming some technical problems with the equipment, laboratory operations resumed in mid-October and tests on the remaining 3,000 (nonfasting) specimens were completed by the end of October. Because of computer problems (usually missing data), only 7,500 machine-printed reports had gone out to the more than 9,000 fasting participants. Now the machine generated only 2,300 more, plus a list of 1,700 serial numbers with computer problems—mainly defects in machine reading of mark-sense sheets, one important programming error, and human errors in recording data. These had to be worked out individually, preventing distribution of further reports until late January, with completion of the task in February 1971.

To assist busy physicians in delivery of risk-factor management, several services have been developed:

1. Group dietary instruction sessions at hospitals, including weight reduction diets, diabetic diets, and lipid-reducing diets.

2. Repeated series of anti-smoking clinics, based on the highly successful approach used in New York by Dr. Donald T. Fredrickson.

3. Further studies of serum lipids (cholesterol, triglycerides, and lipoprotein electrophoresis) at nominal cost.

These services are available to anyone, with preference given to Heart Sunday participants. Diet instruction or lipid profiling require referral by a physician; the anti-smoking clinics are offered directly to the public, in accordance with the response to a mail poll of Dane County Medical Society members. A public education campaign again has begun to emphasize the importance of treating adverse risk factors under supervision of the personal physician.

Finally, recognizing the unique nature of this mass screening on a single day and its possible adaptability to other settings, the planners will prepare a detailed report of the methodology and, when available, the results. Surely this report will caution that such a program cannot be executed elsewhere in exactly this way or at such low cost, but preliminary evaluation to date appears to justify the statement that it was a great success here. □

AMERICAN HEART ASSOCIATION
NORTH CENTRAL REGION

Comprehensive Conference on Stroke

Thursday–Friday, September 23–24

COBO HALL, DETROIT, MICHIGAN

GOAL: To reduce sharply the number of doctors, nurses, and therapists who hold the mistaken belief that little can be done for stroke patients and who consign them to the extended care facility or the unguided care of a wife or a relative.—JOHN GILROY, MD, director, Department of Neurology, Wayne State University School of Medicine, Detroit, and chairman, Conference Planning Committee.

Open to doctors, nurses, therapists, and other paramedical personnel from the North Central Region, the conference is co-sponsored by the AHA's Council on Cerebrovascular Disease. Some sessions will be solely for physicians, while others will be held jointly.

The North Central Region includes: Illinois, Indiana, Kentucky, Michigan, Ohio, and Wisconsin.

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Whipple Resection for Granulomatous Enteritis of Duodenum

By John T. Goswitz, MD,
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GRANULOMATOUS ENTERITIS[1] confined solely to the duodenum is an extremely rare disease. The authors could find only four previous cases reported in the literature.[2] Because of its rarity, disabling symptoms, and difficult treatment, we thought it should be brought to the attention of the medical community.

Case Report. A 51-year-old, white woman, was admitted to the hospital March 7, 1969, with a history of one to two weeks of severe epigastric pain which was steady and associated with persistent nausea and vomiting. She had a six-year history of duodenal ulcer diagnosed as persistently deformed duodenal bulb by x-ray study. No gastric analysis had ever been made. Physical examination showed a thin, chronically ill woman in no distress. No organs or masses were palpable in the abdomen. There was no evidence of jaundice. The hemoglobin was 15.2 gm/100 ml and the white blood cell count was 5,200 with 80% neutrophils, 16% lymphocytes, and 4% monocytes; LE cells were not found: erythrocyte sedimentation rate was 37 mm/hour; urinalysis was normal. Electrolytes showed sodium 137 mEq/L, potassium 4.6 mEq/L, chloride 103 mEq/L, carbon dioxide content 28.8 mEq/L, blood urea nitrogen was 12 mg/100 ml, calcium 9.5 mg/100 ml (normal 9–11), phosphorous 3.3 mg/100 ml (normal 2.4–4.5), alkaline phosphatase 2.0 Bodansky units (normal 1–4), amylase 129 Somogyi units (normal 60–160), serum glutamic oxaloacetic transaminase 16.5 units, and 2 hour postprandial blood sugar 93 mg/100 ml. Twelve-hour overnight gastric secretion produced 1665 ml which was negative for free acid. The chest x-ray film was reported as negative. Upper gastrointestinal series showed a large stomach with retained secretions and evidence of slow emptying. With no free acid, the preoperative diagnosis of a malignancy of the duodenum was made.

She was taken to surgery ten days after admission and exploration was negative except for a mass lesion involving the first and second parts of the duodenum, the head of the pancreas, and the distal part of the stomach. Biopsy of a pyloric node failed to show a malignancy, and the gross appearance was not consistent with ulcer disease. Malignancy could not be established by further frozen section duodenal biopsies, and a specific diagnosis was deferred. The decision to proceed with a Whipple resection was based on the extensive obstructive disease and on the possibility that a malignancy could still be present.

Forty-five percent gastrectomy, 45 percent pancreatectomy, duodenectomy, and cholecystectomy were done. End-to-end choledochojejunostomy, side-to-side gastrojejunostomy and pancreatojejunostomy, and gastrostomy completed the procedure. Her postoperative course was uncomplicated. She began oral feedings on the fifth postoperative day, the gastrostomy tube was removed on the ninth postoperative day, and she was discharged on the eleventh postoperative day. An upper gastrointestinal x-ray series three months and ten months after surgery showed a functioning gastrojejunostomy and no evidence of further enteritis. To the date of this publication, she has remained asymptomatic.

Discussion. The outstanding radiologic feature (Fig 1) was the presence of diffuse narrowing of the duodenum extending from the bulb well into the third portion. There were multiple nodular filling defects noted most prominently in the duodenal bulb and in the proximal portion of the descending limb with tenderness over these areas at fluoroscopy. Marked delay in emptying of the stomach was demonstrated. The radiographic features, alone, could not establish a definitive diagnosis without histopathologic confirmation. The x-ray studies pointed to an inflammatory change within the duodenum and the specific etiology awaited tissue examination.[3,4]

This lesion could not be classified as a typical regional enteritis histopathologically. Inflammatory thickening of the mucosa and submucosa is the predominant change, as well as marked hypertrophy of the muscularis (Fig 2). Although the diagnosis of granulomatous enteritis was confirmed by consultation with the Armed Forces Institute of Pathology and the Pathology Department of the Medical College of Wisconsin, the specific etiology is undetermined. A battery of special stains for organisms also failed to define an etiology for the granulomatous inflammation.

Bypass of a disease process such as this by a gastroenterostomy would seem the logical procedure.[5,6]

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However, in the cases reported by Law, et al,[2] Roberts, et al,[7,8] and Stephens and Randall,[9] the gastroenterostomy functioned poorly, gastric retention was common, and secondary operations had to be performed. Gastroenterostomies function best when they are placed in the prepyloric area, but thickening and induration usually extend into this region. This patient had induration extending well into the antrum. Surgeons are reluctant to place such an important anastomosis in such an obviously diseased area.

On the other hand, resection of the segment of bowel involved with this disease accomplishes several goals. First, the diseased bowel is removed; second, pain from the disease is eliminated; and third, provided meticulous anastomoses are performed, the problems with a bypass gastroenterostomy are excluded.

The postoperative course in this patient makes the Whipple resection a necessary consideration in enteritis of the duodenum. Howard[10] has shown that experienced surgeons have an acceptable mortality rate with this operation. Unfortunately, the small number of these cases reported in the literature makes an accurate appraisal of the best procedure

Fig. 1—Preoperative representative delayed film from upper gastrointestinal series showing narrowing and irregularity of the duodenum and marked stasis of barium in the stomach.

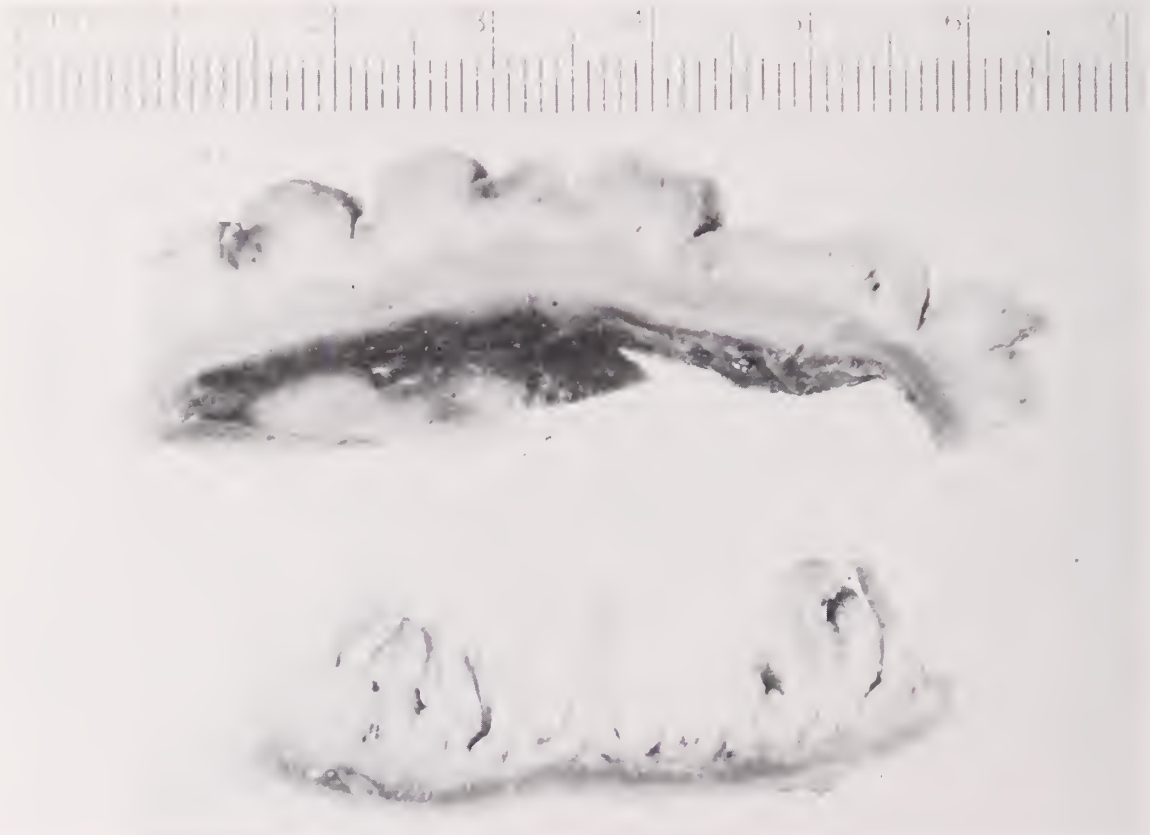

Fig. 2—Upper specimen depicts thickened proximal portion of the duodenum. Lower specimen is from uninvolved distal portion of the duodenum.

rather difficult; yet there are enough reports to illustrate that any procedure short of resection of the disease leaves the patient with the likelihood of symptom recurrence. Although the Whipple resection seems like a radical procedure for benign disease, the long-term result justifies serious consideration of its use.

Summary. Granulomatous enteritis that involves only the duodenum is an extremely rare disease. The patients who have had duodenal involvement have been treated with bypass operations. The results with a bypass have been poor and have frequently not relieved the obstructive symptoms. A case is reported in which a Whipple resection was performed. This operation resulted in complete relief of symptoms in 28 months of follow-up. Consideration for the use of this procedure for patients with this disease is recommended.

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Juvenile Cirrhosis of the Liver and Nephrocalcinosis

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CIRRHOSIS OF THE LIVER in children and adolescents is a relatively uncommon, though not rare, disorder. Unexplained nephrocalcinosis is even less common. In 1968, O'Kell[1] reported 24 autopsies in juvenile cirrhosis cases, finding associated renal lesions in all instances but no nephrocalcinosis. The present report is of the simultaneous occurrence of both these disorders in a young individual.

Case Report. A white woman was first seen at the hospital in April 1960 at the age of sixteen, with a presenting complaint of indolent dermatophytosis of the left foot. There was history of having been evaluated elsewhere, at age thirteen, for amenorrhea persisting after two scanty menstrual cycles; weight loss; polyuria, and polydipsia. Diabetes insipidus had been suspected and there had been a series of injections, with subsequent cyclic hormone therapy for several months. The menses had not reappeared.

Pertinent physical findings at this hospitalization, in addition to the dermatophytosis, were rather dark, almost slate gray skin, scant axillary and pubic hair, slight enlargement of the clitoris. Laboratory study revealed the following: hemoglobin, 13.3 gm/100 ml; hematocrit, 35 vol %; white blood cell count, 4,600 per cu mm with a normal differential; platelets, 146,000; sedimentation rate, 34 mm/hr; serum calcium, 9 mg/100 ml; protein bound iodine, 6.5 mcg/100 ml; 24 hour urinary 17-ketosteroids, 3.5 mg; urinary follicle stimulating hormone greater than 5 mouse units per 24 hours.

Fig. 1—X-ray film revealing diffuse nephrocalcinosis.

The patient was treated symptomatically and discharged without any specific medication. Scant menstrual periods began after leaving the hospital.

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The second hospitalization was in August 1960, just four months after the first, with the complaint at this time of recurrent ankle edema and cellulitis of the left leg. Multiple petechial and spider nevi were observed and there was now hepatosplenomegaly. The laboratory findings were as follows: hemoglobin, 13.9 gm/100 ml; hematocrit, 43 vol %; white blood cell count, 6,900 with 9% eosinophils; platelets, 86,000; total serum protein, 7.4 gm % with a diffuse increase in the gammaglobulins; bilirubin, 1 mg/100 ml direct and 1.3 mg indirect; calcium 9.6 mg/100 ml; alkaline phosphatase, 8.4 units; bromsulphalein retention, 85%; congo red test, 1% retention.

X-ray study revealed diffuse nephrocalcinosis (Fig 1). Liver biopsy showed probable "nutritional cirrhosis." The nephrocalcinosis was unexplained. The urine was negative for abnormal amino-acids.

At this point the patient was referred to the Mayo Clinic, where all the findings were confirmed and the nephrocalcinosis remained unexplained. The cirrhosis was thought to be post-hepatitic and probably resulting from a previous anicteric hepatitis. Prednisone was prescribed, and on this medication the patient gained weight and normal menstruation became established.

The third hospital admission was approximately one year after the second. At this time, aged seventeen, there was still marked splenomegaly but the liver had regressed in size. There had been recurrent cellulitis of the left leg and bilateral pitting edema of the legs. The laboratory findings were: hemoglobin, 11 gm/100 ml; hematocrit, 36 vol %; sedimentation rate, 27 mm/hr; bromsulphalein retention, 33%; blood urea nitrogen, 13 mg/100 ml; serum glutamic oxaloacetic transaminase, 104; total bilirubin, 2.5 mg/100 ml. Serum protein electrophoresis again revealed hypergammaglobulinemia. Urinalysis was negative.

The edema responded to diuretic therapy and the patient was discharged improved. Thereafter, she was seen at frequent intervals for recurrent cellulitis of the leg, recurrent urinary tract infections, and persistent abnormal liver function. A repeat liver biopsy at age eighteen revealed possible post-necrotic cirrhosis.

At age nineteen, she was re-admitted because of anemia. Laboratory findings at this time were: hemoglobin, 7.9 gm/100 ml; hematocrit, 29 vol %; white blood cell count, 5,500; reticulocytes, 2.4%; platelets, 81,000; serum iron, 12 mcg/100 ml. Bone marrow studies suggested blood-loss anemia, but examination failed to reveal evidence of esophageal varices, ulcer, or other bleeding sites.

At age twenty, the patient was delivered of a healthy premature female baby, despite the long-term corticosteroid therapy. At age twenty-two, she underwent splenectomy because of persistent anemia and thrombocytopenia that was unresponsive to corticosteroids. The platelet count promptly rose to normal and remained normal thereafter. Surgical specimens obtained at operation revealed post-hepatitic cirrhosis and chronic interstitial nephritis.

The patient's course during the next two years was marked by low-grade anemia, recurrent urinary tract infections, and persistent abnormality in liver function tests.

The final hospital admission was in February 1969, when the patient was aged twenty-five. At this time there was acute abdominal pain, delirium, high fever, and a rapidly progressing course to death within 48 hours from acute suppurative appendicitis with perforation and peritonitis.

Autopsy revealed post-necrotic cirrhosis, chronic pyelonephritis, and nephrocalcinosis.

In summary, this was the case of a young woman who had evidence of cirrhosis and nephrocalcinosis since the age of sixteen, and known pyelonephritis for at least six years. Despite grossly abnormal liver function, she had remained well compensated for eight years and died suddenly from overwhelming sepsis from appendiceal rupture and peritonitis.

Discussion. In 1957, Ruggieri and associates[2] reported a study of 27 cases of juvenile cirrhosis seen at the Mayo Clinic. The average survival in the series had been 21 months, and in nearly 50 percent of the cases there had been no clear-cut history of antecedent hepatitis or nutritional deficiency. In the 1961 series of Willcox and Isselbacher,[3] comprising 22 females and 11 males, there were several features in common with findings in this patient. Frequently encountered characteristics were recurrent febrile episodes, acne, striae, arthralgia (36%), menstrual abnormalities (either primary or secondary amenorrhea), eosinophilia, elevated gammaglobulin (in all cases). One patient became pregnant, but aborted. There were 3 clear-cut histories of antecedent infectious hepatitis and 4 of probable anicteric hepatitis. The average survival was 3½ years, with a range of 6 months to 8 years. The most common cause of death was hepatic failure and gastrointestinal bleeding.

It may be that in this patient there was a lack of inherent body defense mechanisms against infection that allowed development of both cirrhosis and pyelonephritis at an unusually early age. In this connection, in 1969, Gans and associates[4] described a fascinating new syndrome of antiprotease deficiency associated with infantile hepatic cirrhosis. In their two fatal cases there was relentless liver failure caused by proteolytic enzymes that were apparently released when phagocytes of the reticuloendothelial system filtered out noxious agents delivered via the portal system. It appears that in normal circumstances these enzymes would have been inhibited by the alpha-1 antitrypsin that is absent in the syndrome. It seems very likely that this new entity of Gans should be added to the list of other metabolic disorders associated with childhood cirrhosis: galactosemia, cystic fibrosis, tyrosenemia, glycogen-storage disease, fructose intolerance, Wilson's disease, and hemochromatosis.

The entity known as nephrocalcinosis, which is diffuse renal calcification demonstrable on x-ray film, may result from entirely local causes such as congenital malformations, papillary necrosis, bilateral cortical necrosis, or acute tubular necrosis. The exact relationship of the entity in the few instances in which it has been reported in pyelonephritis and glomerulonephritis is uncertain. Among the various general causes, hypercalcemia should probably be mentioned first because it occurs in a rather large number of maladies, including Cushing's disease, hyperparathyroidism, malignant bone disease, various osteopathies of childhood, cretinism, idiopathic hypercalcemia of infancy, milk alkali syndrome. It is noteworthy that most of the cases of nephrocalcinosis associated with hypercalcemia have occurred in patients with Cushing's disease. Another reported cause has been chronic tubular disease, including

hyperchloremic acidosis; in childhood this may be a transient phenomenon known as Lightwood's syndrome. Another underlying malady may be idiopathic tubular acidosis with hypercalciuria, a urinary pH in the range of 6.5 to 7.0, and hypocitruria—which is known as Butler–Albright syndrome. Oxalosis also has been reported in association with the malady in several instances.

In the 20 cases of nephrocalcinosis that came to autopsy reported by Mortensen and Baggenstoss,[5] in 1954, the calcium deposits were noted in the basement membrane, collecting tubules, medullary interstitial tissue, intracellular epithelial cells of the collecting tubules, intraluminally in the convoluted tubules, in the cortical interstitial tissues, and intramurally in the renal vessels. Obviously there is no definite predilection for deposition of the element in any portion of the renal substance. The immediate causes of death determined at autopsy among these patients were uremia, bronchopneumonia, dehydration, postoperative sepsis, metastatic carcinoma, dissecting aneurysm, parathormone intoxication with hepatic necrosis, postoperative adrenal insufficiency.

In a report from the University College Hospital in London, in 1962,[6] it was said that the ratio of renal calculi to nephrocalcinosis is about 200:1 and that in most series the underlying maladies in 80 percent of the cases were hyperparathyroidism, hyperchloremic acidosis, idiopathic hypercalciuria, medullary sponge kidney, and sarcoidosis, with the remaining 20 percent still unexplained. In 1969, Parfitt[7] reported an interesting case of nephrocalcinosis and nephrolithiasis induced by administration of acetazolamide and sodium bicarbonate, which was thought to have resulted from the inhibition of citrate excretion by the combined action of these agents.

Summary. A case is presented of a young woman who developed idiopathic nephrocalcinosis associated with chronic pyelonephritis and post-hepatitic cirrhosis. She did well on maintenance corticosteroids for at least 8 years and died of an overwhelming sepsis without overt evidence of hepatic decompensation. The unusual combination of nephrocalcinosis with juvenile cirrhosis is still not adequately explained.

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PATIENT ALERT!

Don't

leave things such as this on stairways

A CASE IN POINT

The spout of an oil can penetrated the foot of a 15-year-old boy who was running down the stairs barefoot. The spout was tightly wedged between two of the tarsal bones "like a chisel between rocks." It required a general anesthetic before the doctor was able to remove the oil can from the foot. The photo above shows the tenting of the skin on the dorsum of the foot. The incident was further complicated by the fact that the doctor had to proceed with treatment without parental consent. This points out a second lesson. Parents should keep some responsible adult informed of their whereabouts when minor children are left behind, and preferably they should provide such a person with a written "authorization to any doctor or hospital to provide such care for (your children) as they deem necessary if (the parents) cannot be reached promptly or in a period of time the doctor considers reasonable."

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Submitted by H. W. Bardenwerper, MD
Waterford, Wisconsin

The Journal Editors invite other physicians to submit interesting photographs or brief case reports such as this one to support a continuing effort in providing patients with information that might be helpful in preventing future illness or injury.

Physicians are urged to clip and post this report in their reception areas for the benefit of patients.

Hemangioma of the Parotid Gland in Children

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HEMANGIOMAS OCCURRING in the parotid gland are rare, but it is the most common tumor of the parotid gland in the newborn and infant. They must be carefully distinguished from other tumors which occur in this area so that appropriate treatment is selected. Inflammatory lesions may be caused by a multitude of organisms ranging from bacterial to viral. Benign tumors include neoplastic lesions, hemangiomas, lipomas, cysts, mixed tumors, and papillary cystadenoma lymphomatosum. Malignant tumors include those of connective tissue origin such as sarcomas and those of epithelial origin such as carcinoma, cylindromas and mucoepidermoid tumors. Malignant neoplasms of the lymphatic and nervous systems also would be included.

In this paper the authors present the series of parotid gland tumors operated upon at Milwaukee Children's Hospital from 1940 to 1968, as well as a case report of a parotid hemangioma in a four-month-old infant. Since 1940, nine patients have had parotid surgery at Milwaukee Children's Hospital. The series includes seven hemangiomas, one parotitis and one leukemic infiltration of the parotid gland.

Case Report. A four-month-old white female infant was seen in consultation because of a discolored, elevated fluctuant mass over the angle of the left mandible and pre-auricular area. Discoloration of the skin was first noted when the infant was five days old. The tumor mass presented itself shortly thereafter and exhibited continued growth to age 2½ months. Growth ceased temporarily, and when treated with carbon dioxide snow showed no regression. A conservative observation was elected at this time, but when rapid growth resumed over the next one and a half months, parotidectomy with preservation of the facial nerve was performed.

The specimen consisted of a purplish-red lobular mass measuring 7.5 x 6.0 x 2.5 cm. It was soft in consistency and yet resilient. The mass had a small pseudoencapsulated red grey surface with the parotid gland enmeshed in the tissue.

This solid tumor composed of primitive endothelial lined vascular channels had extensively replaced the parotid gland. Embedded in the tumor were scattered parotid ductules and gland acini. Dilated vascular channels of the tumor extended into the overlying dermis and surrounding fat. No malignant changes were evident.

Discussion. Review of the literature shows that the first evaluation of parotid hemangiomas was performed by McFarland[1] in 1929. At this time he made a thorough review of the literature prior to 1929, as well as a review of available microscopic material. He felt that excess vascular elements were formed at the expense of glandular components leading to disarray and either atrophy or nonformation of secreting portions.

Wawro[2] (1955) felt that these tumors lacked a true capsule allowing local infiltration of adjacent structures. He further noted a time correlation to vascularity of the tumor. Those tumors occurring in patients over six months of age exhibited reduced mitoses, well formed capillary lumina, and generally slower growth; while those in the newborn and very young exhibited a higher degree of endothelial proliferation. It was his opinion that these tumors progressed from the early undifferentiated type to the later more mature lesion.

Campbell,[3] in 1958, attempted to emphasize the importance of recognizing this lesion in infancy. He

Fig. 1—Diffuse, bulky, slightly fluctuant tumor in parotid gland region in four-month-old infant.

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reviewed 58 cases of parotid hemangiomas and added three cases from his own series. It was Campbell's conclusion that cavernous and capillary hemangiomas were not merely differing manifestations of "congenital vascular dysplasia" and neither were they vascular hamartomas. Campbell justifies his belief that parotid hemangiomas are independent lesions by their progressive growth and tissue invasion. He further found no association of these hemangiomas with more serious vascular anomalies.

Bhaskar,[4] in 1963, reviewed the records of 2,500 salivary gland tumors at the Armed Forces Institute of Pathology, and found only 27 salivary gland tumors in patients under five years of age. Ninety-six percent of these were hemangiomas. In Bhaskar's opinion, the juvenile hemangioma was composed of a single cell type, being ovoid or round in shape with a light staining vesicular nucleus and scanty cytoplasm, and that these cells lie in cords de-emphasizing the vascular component of the tumor. This is in contrast to the findings in our patient.

Finally, Scarcella[5] divided parotid hemangiomas into two distinct groups depending upon age—the infant type being hypercellular, lobular, and never appearing to be encapsulated, but rather infiltrating adjacent tissue. The capillaries in these tumors appear to be composed of multiple layers of endothelial cells. Those tumors occurring in children over one year of age tend to be more cavernous in nature and lack the infantile hypercellularity, representing a developmental rather than congenital origin.

Fig. 3—Photograph made during surgery. The bulk of tumor and gland have been dissected from bed. Facial nerve spared by identification and dissection.

Fig. 4—Patient several weeks following parotidectomy. Note facial nerve paralysis on the left side.

Fig. 2—Lateral view showing involvement of skin by tumor. The central white scarring is the result of carbon dioxide application.

Fig. 5—Patient five years following surgery. Although not demonstrated, complete recovery of facial nerve paralysis was evident after eleven months.

Fig. 6—Lateral view. A portion of operation wound scar is noted below ear lobe.

Treatment of parotid hemangiomas in the past have included the injection of sclerosing solutions, radiation treatment, dry ice application and extirpative surgery, and careful observation for involution.

Early workers (McFarland[1]) believed that removal of the entire affected gland was the procedure of choice. Others (Wolfe[6]) feared that the surgical risk was too high in the infant and that the lesion should be allowed to involute spontaneously. Stevenson[7] described a case of a parotid hemangioma which involuted, only to recur sixteen years later, requiring surgical treatment at that time.

Hanna and Gaisford[8] stated that biopsy of parotid gland lesion should be done at the time of definitive procedure with immediate diagnosis by frozen section and that the patient not be subjected to primary aspiration or open biopsy. They also state that management by conservative surgical procedures is adequate in most benign tumors and cysts of the parotid area. The authors heartily concur with this principle. Adequate exposure of the parotid gland with painstaking identification of the facial nerve and its branches is the basis for uncomplicated tumor removal. The superficial position of the facial nerve in infants makes careful identification of the nerve imperative.

In review of parotid gland surgery performed at Milwaukee Children's Hospital by all staff surgeons (including two cases of the authors) hemangioma was by far the most common tumor. This tumor presented itself much more frequently in girl infants, which corresponds with the findings in the reviewed literature.

Parotid gland hemangioma in infants is probably an independent lesion arising from vascular endothelium. When present in newborns, it presents a more primitive cell type and is more cellular. If untreated, it can and probably does progress to a more mature type of cell.

In the reported patients (seven) with parotid gland hemangioma, six were less than nine months of age. The youngest patient was seven weeks old.

Although the predominant solid tumor of parotid gland in the newborn and young infant is hemangioma, differentiation of the tumor is essential for appropriate treatment.

Spontaneous involution of the tumor, as with hemangioma elsewhere particularly in the head and neck region, is possible.

Biopsy by methods other than surgery is contraindicated. The authors would recommend only limited observation. If involution is soon apparent, further observation could be considered. If, however, involution is not evident or progression of tumor is obvious, parotidectomy is indicated. Frozen section examination will establish diagnosis.

TABLE 1

Author	Date	Number	Sex		Age in Years			Type	
			Female	Male	0–1	1–2	Over 2	Capillary	Cavernous
McFarland[1]	1930	40*	20	10	0	39	1	33	7
Howard[9]	1950	16	8	8	0	11	5	12	4
Wawro[2]	1955	10	8	2	7	3	0	10	0
Grage[10]	1961	7	3	4	0	5	2	2	5
Reiguam[11]	1962	10	6	4	0	10	2	10	2
Wolfe[6]	1962	4	3	1	1	2	1	3	0
Bhaskar[4]	1963	22	17	5	16	6	0	22	0
Milwaukee Children's Hospital	1968	7	6	1	0	6	1	5	2 (mixed)

*Sex not reported in 10 patients.

Preservation of the facial nerve, including all branches, is the *sine qua none* of surgery of benign parotid gland tumors in infants or adults. Identification of the main trunk of the facial nerve as it emerges beneath the mastoid process was the location method employed in our surgery.

Again the authors would caution slow and careful dissection because of the superficial location of the nerve in the infant. Only the gentlest retraction on the nerve and its branches should be used.

Forewarning of the patient's parents as to facial nerve paresis or paralysis, almost always present due to handling of nerve, is absolutely necessary. Progressive improvement of facial nerve palsy to full recovery occurs, but it may take several months to a full year.

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Splenic Vein Thrombosis and Bleeding Esophageal Varices

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Splenic vein thrombosis is an infrequently recognized and rarely reported form of extrahepatic venous obstruction. It is clinically important because splenic vein obstruction may cause segmental splenoportal hypertension and the subsequent development of bleeding gastroesophageal varices. The clinical manifestations of segmental portal hypertension are similar to those of generalized portal hypertension, but the treatment is different.

Seven patients with bleeding esophageal varices secondary to splenic vein thrombosis were studied over the past five years. This condition was apparently caused by pancreatitis in five cases, retroperitoneal Hodgkin's disease in one, and shunt surgery in one. Four of the five patients treated by splenectomy are alive without recurrent hemorrhage, from 8 to 60 months after operation. Angiography is the definitive preoperative examination. Splenectomy is the treatment of choice. □

Triple Aorto-Coronary Vein Bypass as Treatment for Coronary Insufficiency

R. J. FLEMMA, MD, W. D. JOHNSON, MD and DERWARD LEPLEY, JR., MD, St. Luke's Hospital and Wood Veterans Administration Hospital, Milwaukee, Wis: *Arch of Surg* 103:82–83 (July) 1971

Triple vein bypass grafts have been carried out in over 57 patients with severe coronary artery disease. The risk is now 5%. The completeness and efficacy of this technique can be attested by the fact that there has been only one late death in this group. Studies of ventricular function have in many instances revealed that it is improved as well as relieved from angina. □

NEW DRUG RESEARCH . . .

Verapamil: Produced antiarrhythmic effects in a group of normal subjects and cardiac patients. The average duration of action after intraventricular injection was 3 hours. By Drs. O. Bass and M. Friedmann, Bezirksspital, Biel, Switzerland.—AMERICAN DRUGGIST, Aug. 9, 1971 □

COMMENTS ON TREATMENT

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Antibiotic Sensitivity Tests: How To Get the Most Out of Them

By Calvin M. Kunin, MD, Madison, Wisconsin

MANY PHYSICIANS BELIEVE that they have met their responsibility by routinely requesting "cultures and sensitivities" on specimens sent for culture. However, few are in a position to determine which of the various tests should be performed or are able to adequately interpret the results. Yet antibiotic sensitivity tests are frequently a major guide to therapy; and if performed or interpreted incorrectly, they may jeopardize good medical management. This report briefly outlines some of the pitfalls in sensitivity testing procedures and offers a scheme that hopefully will improve them.

Unnecessary Sensitivity Tests

A common mistake is to request sensitivity tests on throat cultures. This examination is used only to determine whether group A beta hemolytic streptococci are present. These organisms are fortunately uniformly sensitive to penicillin G and the related members of the penicillin family, penicillin V and ampicillin. Patients thought to be allergic to penicillin may be given erythromycin with equal assurance that the organism will be sensitive. Many strains of group A streptococci (about 15%) are resistant to tetracycline. Tetracyclines should therefore be avoided in treatment of streptococcal sore throat or in the prophylaxis of rheumatic fever. Sensitivity tests are not needed.

Similarly, pneumococci are sensitive to penicillin, erythromycin, and the cephalosporins (cephalothin and cephaloridine). Some strains (about 2%) are resistant to tetracycline. Sensitivity tests are not needed if one avoids the use of the tetracyclines in serious pneumococcal infection. In less acute situations tetracycline may be tried provided one recognizes that resistant strains may be present.

Most clinical bacteriologists are fully aware of the antibiotic sensitivity patterns of pneumococci and group A streptococci and will not perform routine sensitivity tests on these organisms.

Sensitivity Tests on Mixed Flora

A major problem for clinical bacteriology laboratories is the deluge of useless specimens sent for culture and sensitivity tests. This may produce a bottleneck in the operation and delay ability to rapidly process the important specimens or add special procedures that would be of value.

It is virtually impossible to obtain valid information from sensitivity tests performed on mixed cultures. Furthermore, isolation of each individual organism from a mixed culture together with individual sensitivity tests is a considerable burden. This could provide useful information if carefully obtained specimens were promptly sent to the laboratory, but most often the laboratory is asked to process grossly contaminated superficial drainage from chronic wounds or poorly collected sputum samples. Every effort should be made to provide the laboratory with a "good" specimen. For example, in patients with pneumonia, a deep cough specimen which obviously came from the lower respiratory tract or a transtracheal aspiration are needed.

A grossly infected ulcer on an extremity usually contains a wide variety of organisms (frequently gram-negative bacteria and anaerobes) that are not important causes of the infection. The physician should clean away the debris and attempt to collect fresh material from the base of lesion.

Sulfonamide and Methenamine Mandelate

Sensitivity discs are available for testing against these drugs, but they should not be routinely done. The role of sulfonamides has become increasingly less important in chemotherapy because of the abun-

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dance of resistant strains and the advent of more effective agents. Even in uncomplicated urinary infections where sulfonamides still remain useful, sensitivity data are not needed. One can be fairly confident that sulfonamides will be effective in the first few episodes of urinary tract infection in a given patient, but thereafter will be useless. This is probably best explained by the fact that large amounts of sulfonamides appear in the stool where the bowel flora rapidly develops resistance. Reinfection of the urinary tract from bowel flora usually occurs with a resistant strain. For this reason, the patient's history of having recently received sulfonamides is more useful than a sensitivity test. Sulfonamides are sometimes useful in Nocardia infections, but this is rare and is not an argument for routine testing. Furthermore, the recent occurrence of sulfonamide resistant meningococci has virtually eliminated this drug treatment of meningitis.

Methenamine mandelate is a useful agent in prophylaxis of urinary tract infections. Its action depends on an acid pH. There is no need to do sensitivity tests since the agent will usually exert its effect if sufficient amounts appear in the urine and the pH is properly adjusted.

Testing of Multiple Analogues of the Same Drug

This can produce confusion, added expense, and gratuitous information. The only justification is that it permits a pharmaceutical company to advertise its product on a hospital form. For example, in the case of penicillinase producing staphylococci, information from a methicillin sensitivity disc will provide all one needs to know about sensitivity to the related drugs, oxacillin, cloxacillin, dicloxacillin, and nafcillin. A cephalothin disc provides information about the potential efficacy of cephaloridine and cephalexin, and tetracycline disc alone lets you know if the agent will be sensitive to the analogues demethychlortetracycline, methacycline, oxytetracycline, and doxycycline.

In the case of Pseudomonas infections, the polymyxin antibiotics, polymyxin B and colistimethate, are uniformly active. There is actually no need to test against these, but at most one or the other may be included since the information about one is transferable to the other.

Inappropriate Tests

Sensitivity tests may be misleading if run against inappropriate organisms. For example, a staphylococcus may be shown to be sensitive to nitrofurantoin by disc sensitivities. But who, in his right mind, would use this agent to treat staphylococcal bacteremia? Why routinely test staphylococci against tetracycline or chloramphenicol when these are clearly second line agents? Too many nondiscriminating sensitivity tests can provide misinformation and occasionally convince the physician to use the wrong agent.

TABLE 1—*Recommended Routine Antibiotic Sensitivity Tests*

GM + *For Blood* and *Other Infections* with *Staphylococcus*	
Penicillin G, Cephalothin, Methicillin	Routine (3)
Erythromycin, Lincomycin	On special request
GM — (A) *Urinary Tract Infections*	(B) *Blood* and *Draining Wounds* or *Burns, Loaded Sputum* etc.
Tetracycline, Ampicillin, Nitrofurantoin, Nalidixic acid, Kanamycin, Cephalothin — Routine (6)	Tetracycline, Ampicillin, Kanamycin, Streptomycin, Gentamicin, Polymyxin*, Cephalothin — Routine (7)
(C) *Pseudomonas* only	
Gentamicin, Polymyxin*	If known, test only against these 2 drugs
Chloramphenicol	On special request
*or Colistin	
Sensitivity not done on (1) pneumococcus, group A streptococcus (2) few colonies of staph or gram-negative bacilli in sputum (3) mixtures of flora	
Special tests required for (1) Streptococci other than group A in blood (2) Anaerobes (3) Salmonella—Ampicillin and Chloramphenicol (4) Gonococci, meningococci	

To overcome this problem, we have prepared an outline in Table 1 in which the drugs of choice for given infections are selected for appropriate organisms. Note that in all cases the generic name is used to avoid confusion; only a single member of a family and alternate drugs are listed for special situations. For example, routine testing of staphylococci need only give information on the drugs of choice—penicillin G, methicillin, and cephalothin. This will provide virtually all the information needed and can be readily transferred to other analogues. Tests against erythromycin and lincomycin are reserved for special situations where long-term therapy with an oral agent may be needed in an allergic patient. Similarly, simply not including chloramphenicol routinely with the gram-negative series will be effective in limiting the use of the drug.

Anaerobic Organisms and Slow Growers

Routine disc sensitivity tests are not designed to test the sensitivity of these organisms. They should be studied by tube or plate dilution methods. A laboratory freed from the requirement to do unnecessary sensitivity tests on poor specimens will have the time to do these special tests.

The Enterococcus

Enterococci often appear to be resistant to penicillin and streptomycin when tested singly, but are quite sensitive to a mixture of the two. This is well known and usually does not require special sensitivity tests.

When to Ask for Tube Dilution Studies

The management of subacute bacterial endocarditis due to alpha hemolytic streptococci often is aided by information on the exact sensitivity of the organism. Tube dilution tests are often the most helpful guide. In addition unusual organisms and fungi are best tested by this method.

How Can the Laboratory Improve Its Methods?

Sensitivity tests are becoming a more exact science and less of an art. *Simply visualizing a zone of inhibition about a disc does not mean that the antibiotic will be clinically effective or the drug of choice.* Every routine diagnostic bacteriology laboratory should use the reliable Kirby–Bauer method[1,2] for disc sensitivity testing. This method is applicable to staphylococci and the common aerobic gram-negative bacteria. It is designed to provide standard inocula, disc potency, and media. Zone sizes must be measured and compared to a simple nomogram that permits interpretation of zone size into sensitive, intermediate, and resistant strains. The test has been correlated with tube dilution sensitivities and when properly conducted is equally reliable.

How the Clinician Can Help the Laboratory

All too often, the clinician will make seemingly unreasonable demands on the laboratory which in turn will set up arbitrary rules to protect itself. Sometimes both are at fault or have failed to reason situations out to best meet patient needs. The physician can help the laboratory by reducing the load of unneeded tests. The laboratory can help by providing appropriate answers. I hope that this paper will help both.

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2. Petersdorf RG and Sherris JC: Methods and significance of *in vitro* testing of bacterial sensitivity to drugs, *Amer J Med* 39:766, 1965. □

Selective IgA Deficiency: Presentation of 30 Cases and a Review of the Literature

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Medicine 50:223–236 (May) 1971

Although selective IgA deficiency has been known for nearly ten years, no clear-cut clinical syndrome has been found to exist with this deficiency and, in fact, there are reports of perfectly normal individuals with this immunoglobulin abnormality. Because IgA is the major immunoglobulin component of secretions which bathe the eyes, respiratory tract, and gastrointestinal tract, it would be assumed that deficiency of this immunoglobulin system would be associated with recurrent diseases in those areas. In fact, this has not been found to be true.

Our study which was based upon personal experience with 30 patients and a review of over 150 cases from the world's literature uncovered a very high incidence of autoimmune disease and autoimmune phenomenon. This finding in association with the presence of antibodies to milk protein suggested to us that the IgA deficiency of the gastrointestinal tract permitted access to the body of large amounts of animal proteins from food stuffs and that this was a source of constant antigenic stimulation which could possibly result in autoimmune disorders. In addition, individuals with less than adequate protection along the secretory surfaces would receive generous doses of epithelial antigens, such as the glomerular basement membrane antigen, which are normally excreted to the exterior. It has been shown that the receipt of these antigens in rabbits will cause serious kidney disease and we propose that certain autoimmune disorders in man may result from a similar mechanism.

Of interest in this regard are the very large numbers of patients with systemic lupus erythematosus which have been reported with selective IgA deficiency. Another finding of interest is that there are a large number of patients with selective IgA deficiency who develop antibodies to the IgA immunoglobulin and these circulate in their blood. Administration of fresh whole blood to these patients is a dangerous event which can lead to serious anaphylactic reactions. Minor abnormalities of immunoglobulin synthesis were commonly associated in this disorder, suggesting that a more generalized protein disturbance was present.

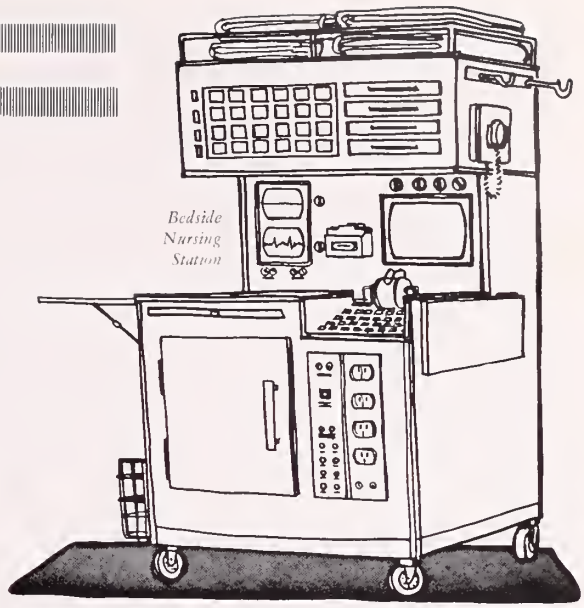
It is also emphasized that there are alternative compensatory roles for immunoglobulin systems in man and to the extent that these are successful, the patients may or may not suffer overt disease. Patients with selective IgA deficiency should be studied carefully and observed for the complications as recorded. □

NEW DRUG RESEARCH . . .

Glibornuride: Provided insulin secretion on a par with tolbutamide. The test drug was administered in intravenous doses of 25 mg while tolbutamide was administered in intravenous doses of 1000 mg. By Dr. P. Bottermann and associates, Munich, W. Germany—AMERICAN DRUGGIST, Aug. 9, 1971 □

Patient-Oriented, MD-Designed Hospital

BURTON A. WAISBREN, MD, Medical College of Wisconsin, Milwaukee, Wis: *Medical Opinion & Review* 6: (July) 1970



In this article are presented the essential components of a patient-oriented hospital that will be amenable to delivery of patient care by a "systems" approach.

Basic to this hospital is a Triage Room, staffed by a "police sergeant" or "military receiving-station sergeant" officer who will have been delegated complete authority by the Chief of the Medical Staff. There are two entrances—elective and ambulance. The Triage Officer will evaluate the patient and then send him, within minutes, through one of five doors.

Door 1. Patients who appear likely to die within 12 hours are sent without delay through Door 1 to the Critical Care Center. Here the patient is evaluated by physicians, and the organ system, whether it be heart, lung, kidney, or gastrointestinal tract, that seems about to give out will be treated immediately. At most, 5 percent of admissions will be sent to the Critical Care Center, which would include an admitting area, recovery room, and acute coronary, burn acute trauma, pulmonary, acute neonatal, and intensive care units.

Door 2. Bed, ambulatory, and psychiatric patients will be sent through Door 2 to the General Hospital Area. Their specific location within that area will be determined by several factors. Interior walls will be movable, making it possible to change the ratio of private rooms to ward beds. Each ward will constitute a family with strong and weak members who will be supportive of each other according to their capabilities and needs. There will be no nursing stations in the General Hospital Area. Each patient will have a bedside nursing machine, and the nurses will circulate from bed to bed, getting their instructions from a communications center by walkie-talkie.

Ninety-five percent of regular hospital admissions will enter the General Hospital Area. On their way they will stop off at the Laboratory Screening Area. All the equipment here is owned and serviced by the hospital, but its standards are quality controlled by an independent agency. Each patient's blood is drawn and run through a simultaneous multiple analysis: hemoglobin, white blood cell count, blood urea nitrogen concentration, cholesterol, sodium, potassium, chloride, serum glutamic pyruvate transaminase, and fasting blood sugar. He then receives a screening electrocardiogram, which is read by an on-line computer, and a full chest x-ray, which is sent to the radiologist for an immediate reading. Blood pressure is measured and a urinalysis also is done. The results of these tests are transmitted by teletype to the patient's chart, within approximately two hours of his admission.

The patient is then taken to his bed, where he is introduced to the nurse who will be responsible for his nursing during that shift. The nurse sees that the patient is comfortable and notes the activities of her shift on a form that is at the bedside nursing machine. She checks the results of the laboratory work and puts into effect contingency orders. For instance, if the patient's temperature is over 101 F, she teletypes the laboratory the infection diagnosis number, so that a technician will come to gather specimens for blood, urine, throat, and stool cultures; if the serum glutamic oxalacetic transaminase is elevated, she teletypes the liver study number; if the blood urea nitrogen concentration is elevated, she teletypes the number of the kidney function diagnosis.

By this time, the patient's physician has arrived. Forearmed with a three-dimensional laboratory picture, he can now examine his patient. He writes his orders at the bedside nursing station. The nurse teletypes them down to the pharmacy, and the physician then dictates a paragraph or two of pertinent points concerning the patient. The physician's observations are typed by the ward transcriber, who also types the nurse's evaluation on the same sheet. The hospital chart, which is kept at the bedside nursing station, consists of progress notes, which doctors, nurses, social workers, and the patient himself have dictated; and the results of laboratory work, typed out for convenience in reading on a linear horizontal basis (since the charges are made by code number in the laboratory itself, laboratory forms do not have to follow billing styles).

If you have followed the train of thought to this point, you will be aware that the "bedside nursing machine" or, if that term is too abrasive, the bedside nursing station, is fundamental to this proposal. The stations will have to be meticulously designed;

they are the key to the flexibility and mobility that permits the dynamic staffing and placement of patients that are also fundamental to this proposal.

The basic unit, which would be used for the ambulatory patient, would have a rack for the patient's chart, a "cardex," a recorder for dictation, a two-way teletype, a radio and small television set for teaching tapes and closed-circuit programs, a small refrigerator for medications, and 24 drawers for medicines.

For the bedrest patient, the basic unit would be expanded to include EKG-monitor inputs, which would be hooked into the "rhythm control room" located in the cardiac critical care area; an O_2 input; a central venous pressure monitoring manometer; and an intermittent positive pressure respirator. Having this a part of the individual station would eliminate an important source of movement and potential contamination.

For use in the Critical Care Center (Door 1) the expanded basic unit would be augmented with equipment for arterial blood pressure and blood gas monitoring. The design would be open ended so that the portable "shock monitoring machine" could be hooked on to it for cardiac output determinations. The critical care bedside station also would have facilities to serve as part of a membrane oxygenator for increasing blood oxygenation (artificial lung), artificial kidney, pump augmentation devices to increase cardiac output (artificial heart), and volume respirators. The latter devices would be engineered to hook into the critical care bedside station as they are needed.

With everything for each patient at his bedside station, the nurse spends fifty minutes of each hour with patients. The last hour of her shift is spent dictating a report on each patient's tape recorder and introducing her replacement to the patient. The new nurse notes the number of patients she will be responsible for during her shift, listens to the taped reports, and delegates specific tasks to the trained practical nurses or aides that are assigned to her.

Each ward will have a communication center staffed by an administrator and ward secretaries. They will have access to a computer to calculate each shift's actual workload, which is determined by analysis of the total ward population. (For instance, on the burn ward at St. Mary's Hospital, we determined that the workload is derived from the number of patients, their mean age, percent of burn, and nursing category.) The ward administrator will then transmit her requirements to the central administrator, who will place incoming personnel on each shift "where the action is." To keep this system completely flexible, as many nurses as possible will have to be qualified for all types of nursing, including critical care. In-service training to this end would be constant.

Door 3. Patients with small lacerations, sore throats, or anxieties will be sent through Door 3 to the Outpatient Surgery. This surgery will be staffed by a trained paramedical person, authorized to give penicillin, sew up cuts, and refer patients to social service agencies.

Door 4. People who come to the emergency admission ward but who really need outpatient care will be sent through Door 4 to the Outpatient Appointment Room. There they will be given appointments to see a physician who is a member of a private group that has contracted for this service. Discussion of these groups is outside the scope of this paper, but suffice it to say that the practitioners will have night office hours, and their office buildings will be located within a few feet of the appointments desk. The appointment clerk will determine the need for evening appointments.

Door 5. Not all who come have to stay, and the Triage Office will know very soon who to send on his way through Door 5, which is an exit.

Summary. How will the patient respond to this hospital setup? He will, of course, be an informed participant in his care. The initial laboratory work will be evidence that things have started. He will be introduced to a nurse on each shift who is *his* nurse, thus he can develop a personal relationship with her. All activity concerning him is concentrated at his bedside, so he is aware of the tremendous effort being made on his behalf. All medication ordered for him is delivered once a day, checked against the orders and placed in the hourly drawers of his nursing station. If he is ambulatory, he will eat with other patients on the ward. He will feel an organic part of the ward community. If he is able, he will participate in group activities and help other patients. He will be able to participate in group therapy sessions to overcome any problems his illness might cause. He will sense that he is being treated as an individual, since he will see his physician read his social worker's or, more ideally, his psychiatric social worker's report on his chart, along with the reports of his physiotherapist, nurse, or anyone else concerned with his care.

What are the advantages of this proposed hospital to the physician who, after all, is the final arbiter of delivery of care to his patient? By the time he arrives at the bedside, results of a comprehensive laboratory screen are available to him. He can always find the nurse personally responsible for his patient. He will meet her at the bedside because there is nowhere else for her to be. He himself will spend more time at the bedside with his patient because he, too, will have nowhere else to be when he is making rounds. The simplification of the chart, with all consultants and ancillary personnel's typewritten comments on simple progress sheets, will keep him up to date on all that is being done for his patient. Finally, the integration into the ward family of a psychiatric social worker, of psychiatric patients, and of psychiatrists will help him to treat his hospitalized patient in greater dimension than is possible while these parameters remain as remote to him as they now generally are. □

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Supernumerary Kidney with Wilms' Tumor

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A SUPERNUMERARY KIDNEY is one of the rarest of renal anomalies. Its occurrence has been carefully recorded in most instances. Since Blasius described the first case in 1677 (basing his report on a case of Martius in 1656),[1] many others have been reported sporadically. In 1950, Carlson summarized 50 cases and added one of his own.[2] Begg reported a case with six functioning kidneys in 1953.[3] Up to date, about 60 authentic supernumerary kidneys have been recorded. Many of the authors have offered excellent reviews of the literature and of the embryological etiology.[1-5] They will not be repeated in detail here.

There is much emphasis as to the definition of a supernumerary kidney which is not to be confused with a double kidney (a more common condition). A double kidney implies a duplication of the renal pelvis, ureter, and blood supply in a kidney which is anatomically a single organ; whereas, the term of "supernumerary kidney" should be reserved for those cases in which there is also a separation of the renal parenchyma into two organs on the same side of the midline.[6]

Approximately two-thirds of supernumerary kidneys have caused symptoms, usually due to infection. Carlson described a case of renal cell carcinoma in both a normal and supernumerary kidney on the same side.[2] Exley and Hotchkiss[1] described a clear cell carcinoma arising in a supernumerary kidney.

A supernumerary kidney usually lies within the renal fascia caudal to the normal organ; however, Burgess[6] reported an unusual case in which the supernumerary kidney was an incidental finding during a common bile duct exploration. It was located medially and ventrally and was in close contact with the common bile duct.

There are reported cases of Wilms' tumor in a horseshoe kidney,[7] but a Wilms' tumor arising from a supernumerary kidney has never been reported.

Case Report. A seven-year-old white girl was well until approximately two weeks prior to her first hospital admission on Nov. 15, 1966, after she had fallen on her abdomen and complained of abdominal pains. The diagnostic examination, including an intravenous pyelogram, a retrograde pyelogram, and barium enema x-ray study, revealed a mass in the mid-portion of the left retroperitoneal space with displacement of the left ureter far to the left. The mass was not contiguous with the kidney and was thought to be a lymphosarcoma on the original films. A laparotomy was performed. On opening the peritoneal cavity, a large and encapsulated mass about 9 cm in diameter was found immediately under the line of incision. It arose from the left inferior retroperitoneum at the level of the innominate line of the pelvis; the mesentery of the sigmoid was intimately adherent to the mass. Further dissection revealed that the tumor was arising from the posterior pelvic wall between the left common iliac artery and vein. During the operation, there was considerable spilling of the necrotic tumor tissue into the peritoneal cavity. The specimen received by the pathologist was described as multiple, grayish-tan, rubbery, irregular, and friable soft tissue fragments weighing approximately 50 gm in total.

Under the microscope, the lesion was found to be composed of an embryonal type of fibrovascular stroma containing irregular and branching groups of epithelial-like, spindle-shaped cells exhibiting a tendency to form tubular structures closely resembling renal tubules (Figs 1a and 1b). Within the stroma, small numbers of cells with abundant eosinophilic cytoplasm containing cross striations were observed (Fig 2). There were areas showing a more mature fibrous stroma with numerous primitive and differentiated glomeruli and a few renal tubules (Figs 3a and 3b). Thus, the sections were strongly suggestive of a hypoplastic supernumerary kidney with a Wilms' tumor arising from it.

Subsequently, the patient was treated with radiotherapy (x-ray and Co^{60}), actinomycin-D, and vincristine in a university hospital.

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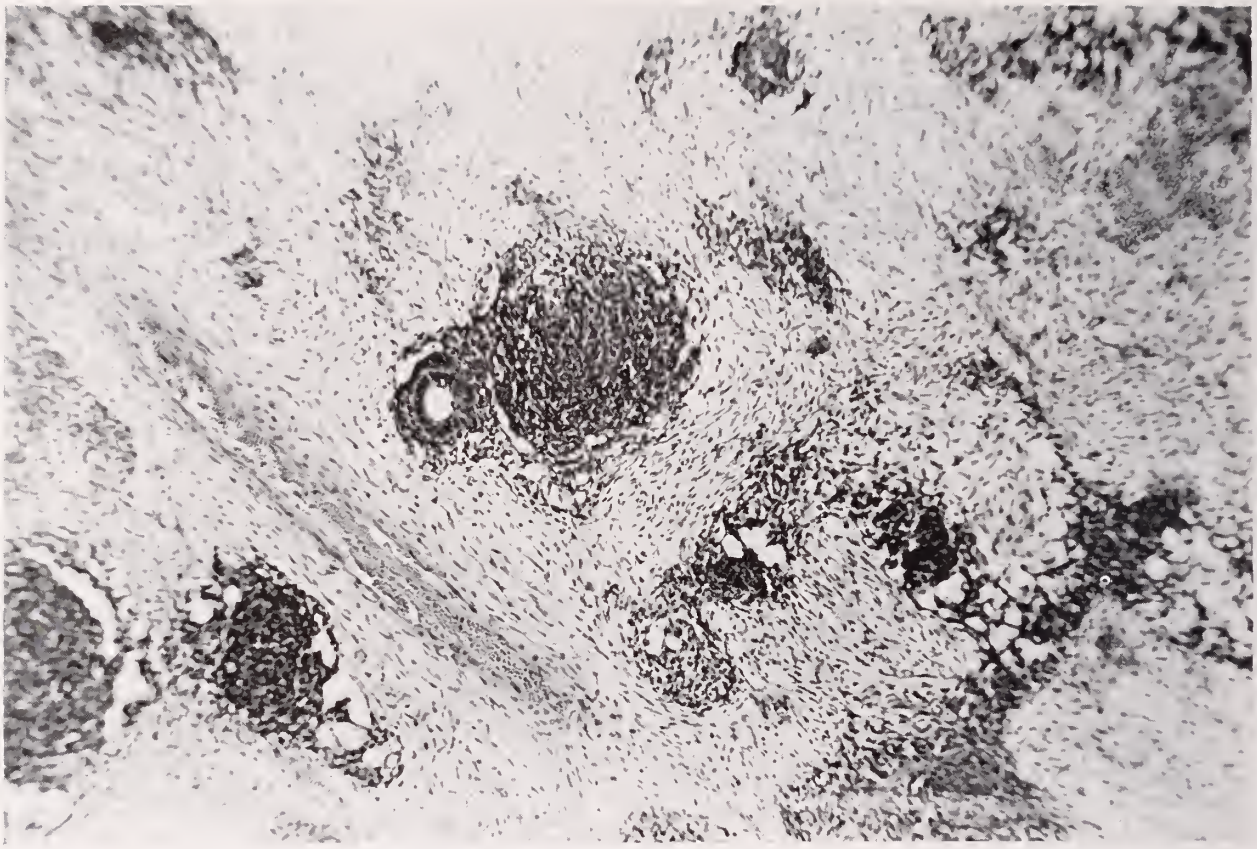
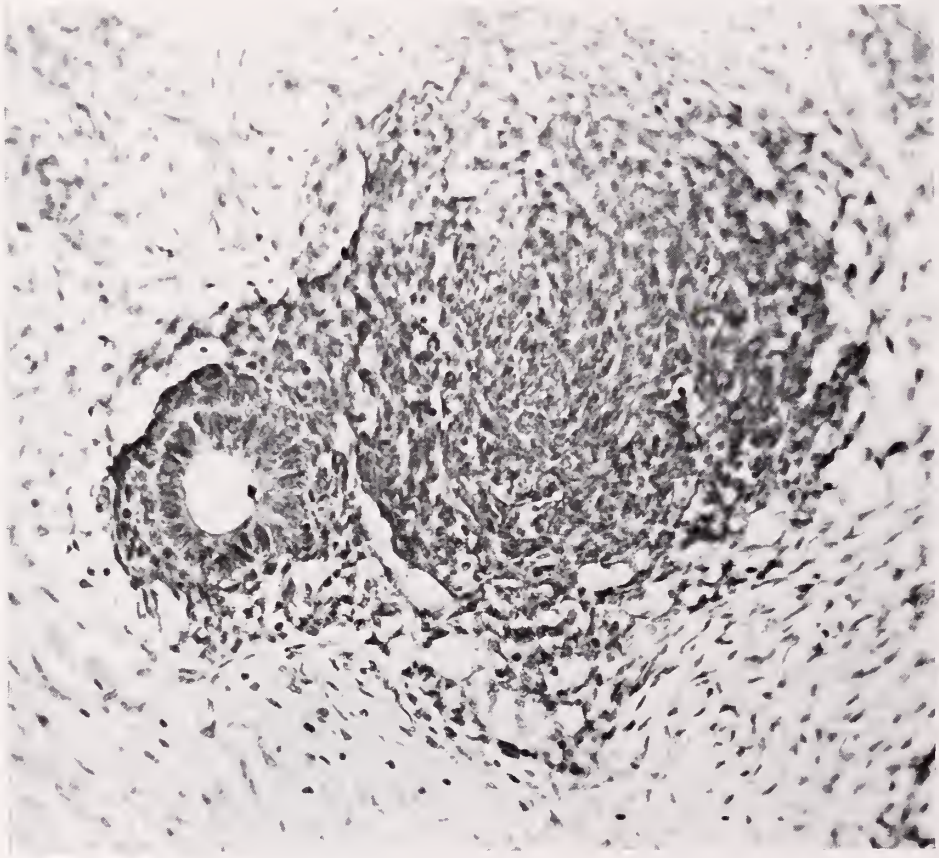


1a



1b

Figs. 1a and 1b—Well-formed tubules and groups of primitive mesenchymal cells supported by a loose stroma. (Hematoxylin and eosin. Fig 1a mag. 100x and Fig. 1b mag. 260x)

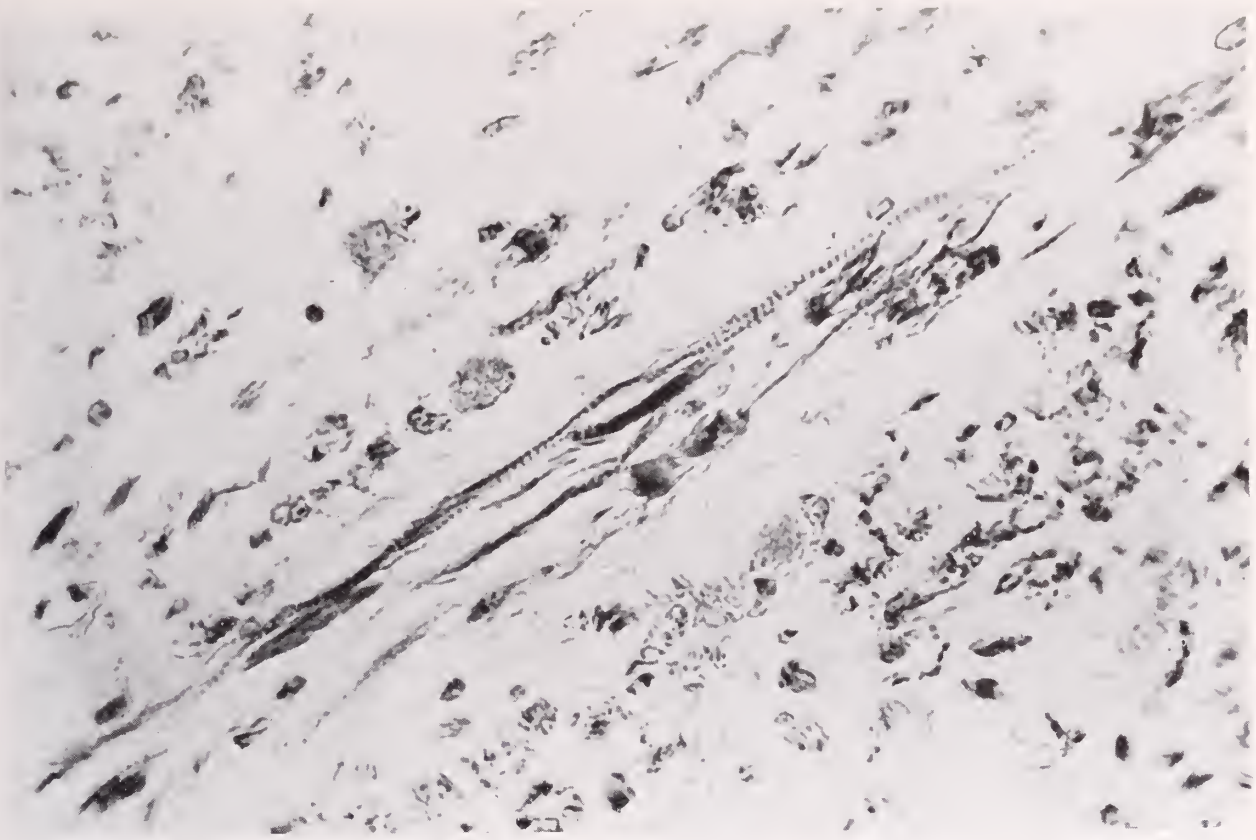


Fig. 2—Muscle fibers with cross striations. (Phosphotungstic acid and hematoxylin. Mag. 600x)

About five months later, the patient's abdomen became markedly distended, and her condition deteriorated in spite of re-administration of the actinomycin and Co^{60}. She died on Oct. 21, 1967, approximately one year after discovery of the tumor.

Autopsy Findings. The body was that of an emaciated girl with a large retroperitoneal tumor infiltrating the peritoneal space and the capsule of the liver. There was no connection between the retroperitoneal tumor and both kidneys. The kidneys were essentially unremarkable (Fig 4) except for a slight to moderate degree of focal interstitial or glomerular fibrosis and thickening of the blood vessel walls. These changes were thought to be due to radiation therapy. Careful dissection of the ureters failed to reveal abnormal branching. Both ureters followed a normal course and entered the bladder in a normal fashion. The tumor growth was limited to the abdominal cavity with infiltration to the serosa of the colon, the ileum, the capsule of the liver, and the peritoneal surface of the diaphragm.

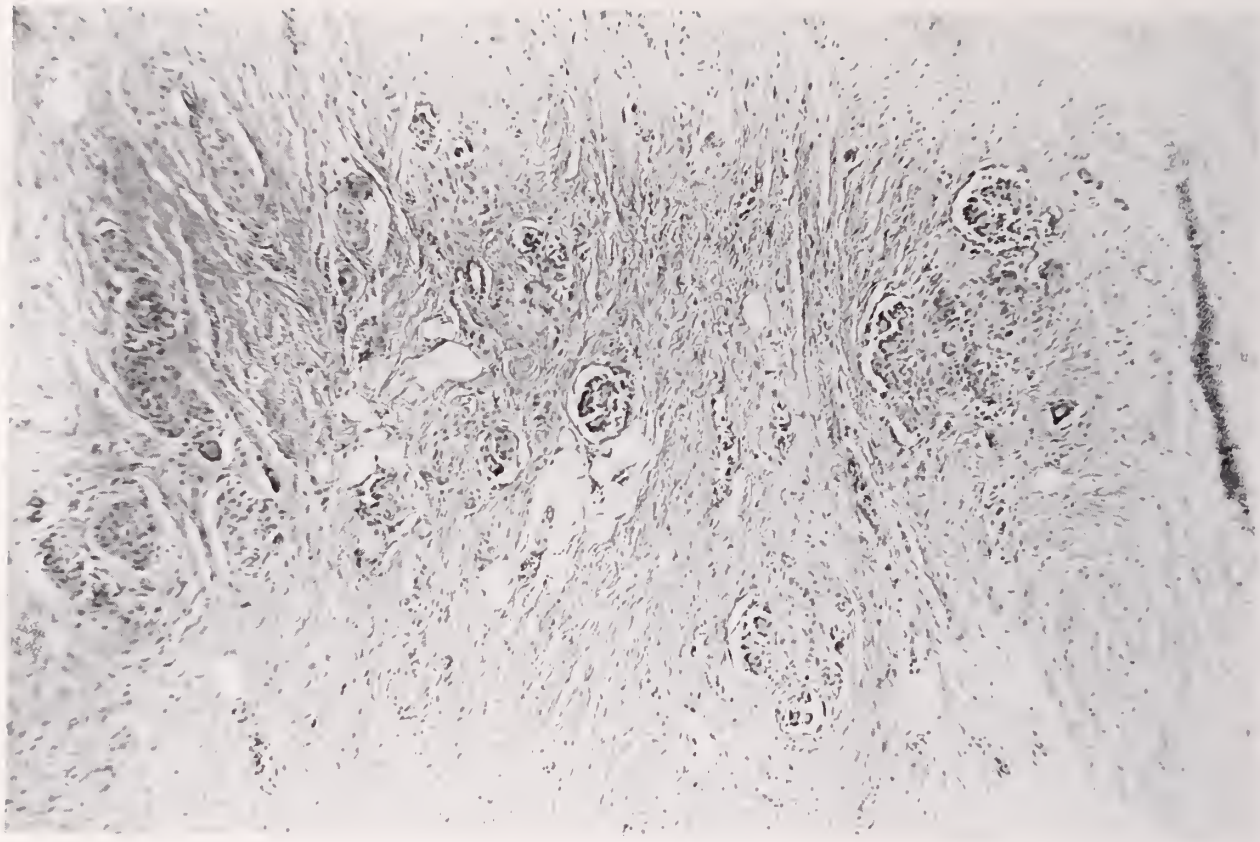
Both ovaries were intact and normal sized with a few simple microscopic cysts.

The microscopic examination of the tumor revealed histologic patterns varying from area to area. There were clusters of immature mesenchymal cells and tubular structures surrounded by a myxomatous stroma (Fig 5) with areas composed of muscle fibers containing cross striations. A good portion of the tumor was made up of spindle-shaped sarcomatous cells. All features were similar to those found in the biopsy specimen.

Comments. A case of Wilms' tumor arising from an ectopic supernumerary kidney is reported. It is a tumor with features common to Wilms' tumor such as an embryonal stroma, tubular structures, and striated muscle components, a tumor with the existence of well-differentiated renal glomeruli and without taking origin from any organ including both kidneys. Could this be a teratoid tumor arising from the ovary? This possibility can be safely ruled out by the presence of bilateral normal ovaries both grossly and microscopically. The presence of well-differentiated glomeruli in some of the sections from the tumor mass removed in 1966 during the initial hospitalization indicated that the tumor arose from the ectopic renal tissue; indeed the possibility that these glomeruli are neoplastic is unlikely because it is well accepted that true glomeruli are rarely of a neoplastic origin, and that when they are found in a tumor, they represent remnants of kidney tissue which persisted in spite of neoplastic invasion.

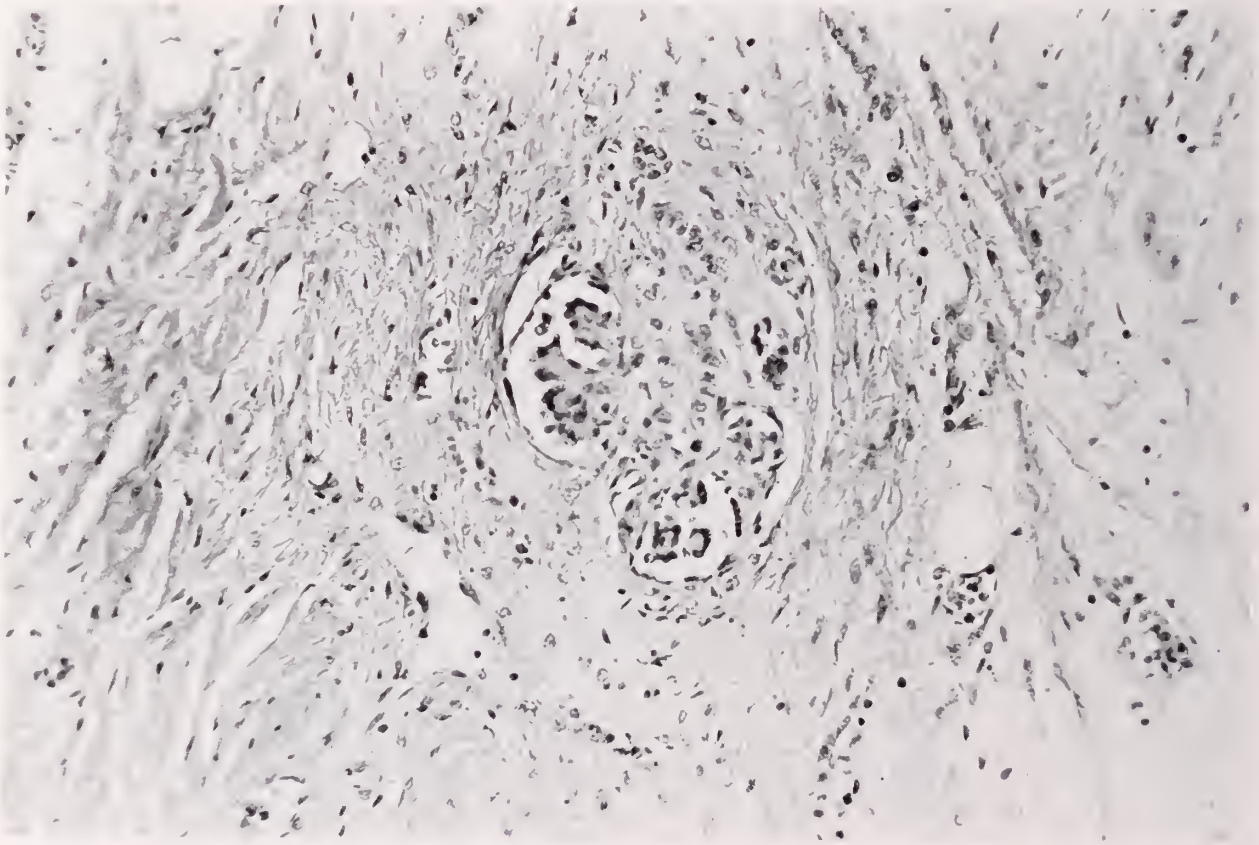
An intravenous pyelogram and retrograde pyelogram failed to reveal any communication between the ectopic renal tissue and the normal urinary system. Postmortem examination failed to disclose abnormal branching or extra-orifices in the ureters. Therefore, we can assume that the third renal tissue was probably non-functioning.

A Wilms' tumor is mesodermal in origin, and all are from the primitive renal blastema; the ultimate histologic diagnosis rests upon the identification of primitive organoid structures of glomeruli and tubules as well as the presence of striated muscle fibers. A Wilms' tumor can arise, therefore, from aberrant renal tissue just as a breast carcinoma can



3a

3b



Figs. 3a and 3b—Many well-differentiated glomeruli. (Hematoxylin and eosin. Fig. 3a mag. 100x and Fig. 3b mag. 250x)

Fig. 4—Bilateral kidneys, free of tumor.

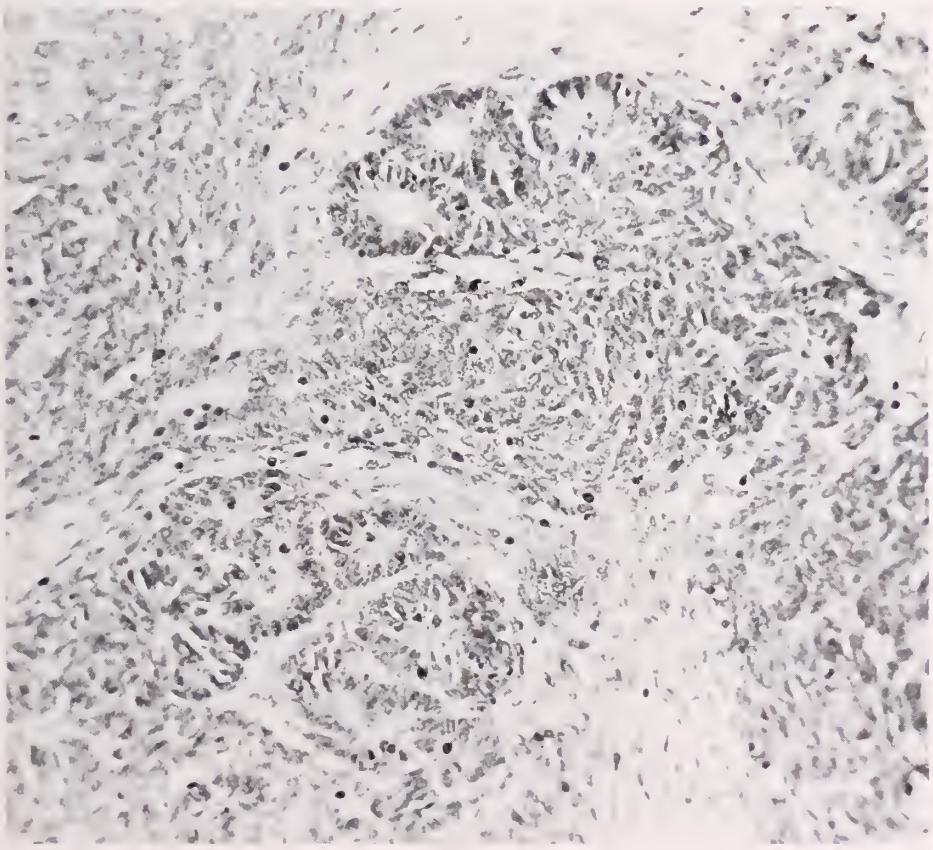


Fig. 5—Clusters of embryonal mesenchymal cells and tubular structures surrounded by a myxomatous stroma. (Hematoxylin and eosin. Mag. 260x)

Clinical Evaluation of Highly Water-Soluble Steroids in the Treatment of Cerebral Edema of Neoplastic Origin (A Double Blind Study)

HARVEY J HOYT, MD, Squibb Institute for Medical Research, New Brunswick, NJ; FRANK P GOLDSTEIN, MD, DONALD H REIGEL, MD and ROBERT HOLST, MD, Department of Neurosurgery, Medical College of Wisconsin, Milwaukee, Wis: *Clin Pharm & Ther* 12 (No 2, Pt 1):291–292 (Mar–Apr) 1971.

The efficacy of highly water-soluble steroids in the treatment of cerebral edema secondary to cerebral neoplasms had not previously been evaluated in a double blind study. Cerebral neoplasms were evaluated radiologically, and pathologic confirmation was obtained in 22 patients following surgery. Patients were placed preoperatively on equivalent doses of one of three medications, dexamethasone 21-sodium phosphate, triamcinolone acetonide 21-dipotassium phosphate (SQ15,935, Squibb Institute for Medical Research), or placebo. Medication was assigned sequentially in random order. Patients were treated from 2 to 7 days preoperatively and 14 days postoperatively. Efficacy was determined by noting the degree of swelling of the brain at surgery, and the level of consciousness and neurologic deficit throughout the study. Fifteen of 16 patients who received steroids demonstrated a marked response to medication, while none of 6 patients who received placebo responded (two of these were terminal and could not be evaluated). Based on this limited clinical double blind study, the use of steroids appears to be valuable in the treatment of cerebral edema of neoplastic origin. □

Hepatic and Erythropoietic Protoporphyria

D J CRIPPS, MD and W N MacEACHERN, MD, University Hospitals, Madison, Wis: *Arch Path* 91:497–505 (June) 1971

This report presents chemical, pathological, and fluorescence-microscopy evidence that in erythropoietic protoporphyria (EPP), the site of porphyrin synthesis is both hepatic and erythropoietic. Erythrocytic and stool porphyrins determined during 18 months on brother and sister with EPP showed significant variation, and stool protoporphyrin quantity was independent of erythrocytic breakdown. Hepatic δ-aminolevulinic acid synthetase was increased in both, but not in a third (unrelated) EPP case. Fluorescence microscopy and microfluorospectrophotometry of marrow and liver cells indicated protoporphyrin which was present in hepatic cell cytoplasm as focal deposits, corresponding to brown pigment on hematoxylin-eosin sections. Percentages of fluorescing erythrocytes in brother and sister were 15% and 12%, and identified bone marrow cells also showed similar proportions of fluorescing normoblasts, with largely cytoplasmic fluorescence. Examination of hemolyzed fluorocytes indicated protoporphyrin in the hemoglobin supernatant fraction and not attached to the lipid cell membrane. □

Inhibition of Migration of Human Autogenous and Allogeneic Leukocytes by Extracts of Patients' Cancers

W H WOLBERG, MD, University of Wisconsin Medical Center, Madison, Wis: *Cancer Res* 31:798–802 (June) 1971

Studies have shown the importance of the delayed hypersensitivity reaction in the body's defense against cancer. Production of migration-inhibitory factors is characteristic of the delayed hypersensitivity reaction. Delayed hypersensitivity to chemically induced tumors has been demonstrated in animals by inhibition of macrophage migration.

In our study, preparations from 19 of 21 human tumors inhibited leukocyte migration. Some preparations were cytotoxic to both autogenous and allogeneic migrating leukocytes. Growth of heterologous hepatoma cells in tissue culture was not inhibited by some preparations that inhibited leukocyte migration. It appears that both cytotoxic and migration-inhibiting substances can be liberated by tumor-leukocyte interaction. Such factors may prevent interaction between white blood cells and human tumors and thereby inhibit the cellular immune response in cancer patients. □

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arise from aberrant breast tissue. In reviewing the literature on Wilms' tumor,[7–9] one is unable to find a Wilms' tumor described outside the kidney or with no direct connection with the renal capsule or parenchyma.

ACKNOWLEDGMENTS: We wish to express our thanks to Dr. Donald Stevenson for allowing us to use the biopsy slides and to Dr. Walter H. Jaeschke and Dr. Franz Gosset for reviewing the manuscript.

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Complications of Rubella Vaccine Inoculation Among 8,051 School Children

By Domingo Leonida, MD
Kenosha, Wisconsin

FOR MANY YEARS man has been intrigued by the biologic effects of rubella virus. Its teratogenic effects have been observed by Gregg.[1] The rubella epidemic of 1964–1965 left in its wake over 20,000 affected children. The technical means are at hand for eventual elimination of rubella from the United States.[2] Live, attenuated rubella vaccine has been developed and extensively tested.[3, 4] Mass rubella vaccination programs are currently in progress.[5]

Rubella is not highly communicable except under conditions of close contact such as exist in the family setting. Susceptibility to rubella virus is unusually prevalent in certain adolescent and adult populations. The high susceptibility rate in females of childbearing age constitutes an important public health problem requiring interruption of rubella transmission.[6]

In the United States, some 80% of people by the age of 15 to 19 years have been infected and are immune to rubella and the percentage rises with increasing age.[7]

The studies with HPV-77 virus in duck embryo cell culture, carried out in families in the open community, have proved the safety and the efficacy of such vaccination procedure and provide a basis for expanding studies evolving into a community-wide program.[8]

Complications of rubella include arthralgia, fever, rash, adenopathy, arthritis, rarely encephalitis.[9]

On January 15, 1970, the vaccination of kindergarten children began. A physician, two nurses, and two to three volunteer school mothers made up the team visiting each public and private school. Using individual disposable syringes, up to 100 injections per hour were given. There were no immediate untoward effects noted. Each school was requested to notify the local health department about any complaint regarding the inoculations. Make-up clinics were held at each school four months later. Weekly surveillance for rash, joint pains, glandular swelling, fever, and any complaints for four weeks after inoculation was carried out. Lyovac,® Meruvax® (Rubella Virus Vaccine), prepared in cell cultures of duck embryo (Duck cell adapted HPV-77 strain, passage S). Administration of the vaccine was carried out by the same physician using the disposable needles and syringes. 8,051 children from nursery schools, head start programs, kindergarten, first grade and second grade in both private and public schools of the city of Kenosha and adjacent areas of Kenosha county were vaccinated starting January 15, 1970, and continued through May 10, 1970. The priorities considered in selecting schools in a rubella immunization plan were as follows:

(1) High density of susceptibles in the population at large,[10]
(2) Where mobile population is highest,
(3) Where preventive, medical services are low in priority,
(4) High susceptible population density per school class, and
(5) Where housing tends to be built closer to one another.

TABLE 1: *Frequency of complications*

	f.	Incubation Period (Days)	Sex	Age (Years) 3	4	5	6	7	8
Fever	5	(2–30)	3M 2F	1	2		1	1	
Adenopathy	6	(2–11)	2F 4M	1	2	2	1		
Joint pain	3	(4–10)	2M 1F				1		2
Rash	9	(2–30)	6M 3F	2	3	2	2		
Chills	1	(2)	1M			1			
Nausea vomiting	1	(2)	1M			1			
Dizziness	1	(2)	1M			1			
Sore throat	2	(6–8)	2F		1	1			
Lethargy or malaise	1	(9)	1F			1			
Myalgia	2	(4–5)	1M 1F			1		1	

Results. Most frequent combinations of symptoms were rash and fever (4). A total of 15 children were examined and their parent(s) were interviewed by the public health nurse(s)/school health physician. Six other children were reported as having had a rash 3–9 days after receiving rubella vaccine but the rash disappeared after a few hours by the time examination was attempted and thus were not included in Table 1. All of the following were transitory and required no treatment.

Fever _____ 101 to 103 F, 2–30 days after vaccination

Adenopathy ____ mastoid and/or occipital nodes 2–11 days after vaccination

Joint pain _____ 4–10 days after vaccination, transient

Rash _____ 2–30 days after vaccination, macular rash.

Sore throat _____ 6–8 days after vaccination, mild pharyngitis.

Myalgia _____ 4–5 days after vaccination, transient.

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TABLE 2: *Probability of complications to rubella vaccine*

Complications	Frequency	Combined Rate	Sex	Rate	
Fever	5	5 15	2F 3M	2 15(F)	3 15(M)
Adenopathy	6	6 15	2F 4M	2 15(F)	4 15(M)
Joint pain	3	3 15	1F 2M	1 15(F)	4 15(M)
Rash	9	9 15	3F 6M	3 15(F)	6 15(M)

	Age (Years)					
	3	4	5	6	7	8
Fever	1	2		1	1	
Chills			1			
Adenopathy	1	2	2	1		
Nausea vomiting			1			
Joint pain				1		2
Dizziness			1			
Myalgia			1		1	
Rash	2	3	2	2		
Sore throat		1	1			
Total Complications by Age	4	8	9	5	2	2
Rate by Age	4 15	8 15	9 15	5 15	2 15	2 15

Discussion. The possibility that concurrent incubation of other microbes could occur with rubella vaccination has not been overlooked. When considering these symptoms and signs, differential diagnoses must be reviewed. The most frequent combinations of complications were rash and fever. The most common complications of rubella vaccinations were rash, adenopathy, fever, and joint pains. Also such possible minor complications as fever alone might not have been reported adequately. The probability of each complication among those who developed complications during the rubella vaccine inoculation is given in Table 2. The significance of ecological factors influencing disease in human communities is well known.[11]

The probability of complications occurring in rubella vaccine inoculation for a school population of this size (8,051) was 1:537. For every 537 children receiving the vaccine, one child may possibly have a complication. Among those developing one or more complications, the probability of fever was 1:3, 1:2 for adenopathy, 1:5 for joint pain or tenderness, 3:5 for rash resembling rubella. Rash was the most commonly occurring complication.

Also among the children developing complications, the occurrence of fever was 1:8 for girls and 1:5 for boys; the occurrence of adenopathy was 1:8 for girls and 1:4 for boys; the occurrence of joint pain was 1:15 for girls and 1:8 for boys; and the occurrence of rash among girls was 1:5, while among boys it was 1:2. Joint pain was rare among girls. Rash was common among boys.

Also among those having complications to rubella vaccination, the rate of complications among the different ages were 1:4 in the three-year-olds, 1:2 in four-year-olds, 3:5 in five-year-olds, 1:3 in six-year-olds, 1:8 among both the seven- and eight-year-olds. The probability of complications singly or combinations was highest for five- and four-year-old children receiving this type of rubella vaccine.

Conclusion. The ecological implications in the results noted require elaboration. A subpopulation of 8,051 children, within a school system of over 27,000 plus 4,000 more for the nursery or preschool children, was our target group for rubella vaccine inoculation. The possibility of concurrent incubation of a variety of microbes in such a subpopulation, in a population of about 31,000 children within a greater mixed population of over 80,000 people, is a realistic consideration. Hence, differential diagnoses are reviewed each time a complication to vaccination is reported. For this subpopulation, within Kenosha's environment, the rate of complications had a possibility of 1:3 for fever, 1:2 for adenopathy, 1:5 for arthralgia, 3:5 for eczemata resembling rubella. Rash was the most common complication in this group of children.

The impact of ecology both external and internal is further demonstrated in terms of sex within the population receiving the rubella vaccine. The occurrence of fever among the 15 children was 1:8 for girls but 1:5 for boys; adenopathy was 1:8 for girls but 1:4 for boys; eczemata was 1:5 for girls but 1:2 for boys; and arthralgia was rare among girls 1:5 while more common among boys. Rash was most common among boys.

Also, as a further reflection of ecological characteristics of the vaccinated population complications were contrasted in terms of chronological age. The rate of complications was 1:4 among three-year-olds, 1:2 among four-year-olds, 3:5 among five-year-olds, 1:3 among six-year-olds, and 1:8 for both seven- and eight-year-olds. The probability of complications singly or combinations was highest for the five- and four-year-old children.

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Community German Measles Testing

By John A. Bacharach, BS, MPH
Eau Claire, Wisconsin

THE BOARD OF HEALTH in December 1969 after discussing the German measles problem decided that the most effective and economical approach to reduce the dangers of the predicted German measles epidemic would be to offer a test to all women between the ages of 14 and 35 in the county to determine if they were susceptible to the disease. If they were, vaccine would be offered to their physician in case he decided to immunize them. The program was unanimously endorsed by the County Medical Society in January 1970.

Meetings were held with both Sacred Heart and Luther hospital pathologists; and it was decided, since Luther personnel had been trained by the State Laboratory of Hygiene to carry out the hemagglutination inhibition test, only one hospital would run the blood tests. The results of the test were interpreted as follows: A titer of less than 1:10 was considered negative. A titer of more than 1:10 but less than 1:40 was considered questionable, while a titer of 1:40 or more was considered positive for German measles immunity.

To draw the blood, the Medical Technologist Association was contacted and its members volunteered to serve at the clinics and to help plan them. It was decided to have at least three centers that could handle at least 1,000 persons each in 3 to 4 hours.

The public health nurses handled the clinic operation, registration, and arranged for the supplies and recruiting the additional 200 volunteers needed to man each center.

The County Medical Society agreed to have at least one physician at each clinic to supervise the operation and handle any unusual medical problems that might arise.

Registration cards were developed for the program that could be tabulated on automated data processing equipment. A sequential duplicate numbering system was used with one number being placed on the registration card and a second identical number on the Vacutainer® which was given to the individual whose blood was to be tested. To guard against mistakes, the registrant was asked to check the numbers, as was a volunteer who supervised the waiting women.

The data processing cards also contained questions concerning whether the individual thought he had had the disease or not or whether he wasn't sure. The cards also contained information to determine if the person lived in the city or rural area, their age and if they were immunized against German measles. In this way we hoped to learn what percentage of the women could provide accurate information concerning a history of German measles.

Since we expected only those who had not had the disease or were not sure to attend the clinic, we did not feel we could ascertain the percentage of women in the community who could be expected to be immune because of the biased sample. The results, therefore, were rather surprising, since of the 1,996 women tested, 89% were considered immune by our standards and the result of natural immunity. Of the 1,444 women tested and residing in the city, 89% were immune in contrast to 341 women in the county of which 92% were immune. In only eight cases were the results questionable.

A breakdown of the results indicates that 88% of the under-20 age group has immunity, 91% of the 20-to-29 age group has immunity and 92% of the 30-to-39 age group. The totals in each category were 877, 803, and 100 respectively.

A closer look at the individual age groups under 20 reveals the following progression of immunity:

Age	*Number of Women*	*Percentage Immune (%)*
14	89	84
15	124	82
16	106	74
17	136	91
18	209	94
19	206	95

The results of the question concerning knowledge of German measles infection indicated that of 153 who answered by indicating they had the disease, 92% were correct. However, the 140 who were correct represented 8% of the total 1,785 who were positive for German measles. Of 338 who indicated no history of German measles, 86% or 289 were incorrect with only 14% giving correct answers.

The group indicating an uncertain history of German measles totaled 1,505 women. Of these, 90% were found to have immunity. Thus, only 8% of the total thought they had immunity, 17% thought they were not immune and 75% didn't know. It must, however, be remembered that for even the group who thought they had immunity, they attended the clinic because there must have been some doubt in their mind.

Vaccine was distributed to 87 persons for use by physicians for those women who had no immunity. Although the count was less than the 203 with no immunity and the eight questionable, we know that not all physicians and/or patients who

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This paper is sponsored by William J. Beckfield, MD, pathologist at Luther Hospital, Eau Claire.

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received the vaccine obtained it from the Health Department. Consequently, no conclusion was possible as to how many of those who were not immune actually received the vaccine.

Discussion. The cost of the program totaled $2,800.00 and consisted exclusively of materials, supplies, and laboratory costs. Material including postage totaled $1,120.00; vaccine $200.00 and the laboratory tests at cost totaled $1,479.26. This cost does not reflect the actual cost because of the many volunteers consisting of medical technologists, parents, nurses, doctors, and students who made the program possible, in addition to the Health Department staff.

The almost 2,000 women represent just under one third of the estimated women in the childbearing age group. We also know that 3,600 cases of German measles were reported to the Health Department in 1964 during the last epidemic.

Because of the biased nature of the program, it is difficult to arrive at any conclusion about the immune status of the community, although the results are in agreement with the level of immunity generally found in other surveys and higher than others.[1, 2] However, it was unfortunate that the titer level used to determine immunity was so low, since it would have been interesting to record variations in natural immunity in the community. No person who had been vaccinated attended the clinic.

An interesting side effect of the publicity of the program was that additional women began requesting the test of their private physicians. Participants frequently called to find out what their test results had shown since they wanted this information before becoming pregnant. The increase in community awareness of the importance of German measles tests led to the second hospital in the community to also institute a testing program.

The Board of Health also plans to institute a similar testing program for girls in school of age 14 to 18 in four years to again find the young women who may not have acquired natural immunity and give them the opportunity of German measles immunization.

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Artificial Sweeteners as Urinary Bladder Carcinogens

G T BRYAN, MD and O YOSHIDA, MD, University of Wisconsin Medical School, Madison, Wis: *Arch Environ Health* 23:6–12 (July) 1971

Four out of every five cancers in man may have their origin in the environment, and about 90% of human neoplasms may be due to chemicals. In an effort to reduce the incidence of human cancers, efforts might be directed toward identifying environmental carcinogens, and, where practicable and possible, removing these hazards from the environment.

Only chemicals have conclusively induced bladder carcinomas in man and experimental animals; some of these compounds cause a nearly 100% incidence of bladder cancer in groups of workers intensively exposed to them. However, not more than 1% of bladder cancers can be attributed to exposure to these chemicals and the incidence of human bladder cancer appears to be rising.

Two methods of chemical administration have been employed to study experimental bladder carcinogenesis—systemic or oral administration, and direct application of the test compound to the urinary bladder mucosa, *e.g.*, pellet implantation. More than 160 chemicals have been tested by the pellet implantation technique in the mouse; bladder carcinogenicity has been observed for only 56 compounds (35%). Seventeen chemicals or substances, or their urinary metabolites, which showed bladder carcinogenicity by intravesical implantation also demonstrated bladder carcinogenicity in one or more species, including man, when administered systemically. Bladder carcinogenicity was first demonstrated for cyclamate sodium, 1-(2, 5-dimethoxyphenylazo)-2-naphthol, formic acid 2-[4-(5-nitro-2-furyl)-2-thiazolyl] hydrazide, and bracken fern, by the pellet implantation method prior to confirmation by systemic administration to test animals.

Recently saccharin sodium conclusively was demonstrated in our laboratory to be a bladder carcinogen by the pellet implantation technique. Since no adequate study of its carcinogenicity has yet been conducted and completed in animals by systemic routes of administration, it would appear most prudent at this time to limit utilization of saccharin to diabetics, the severely obese, and others with specific medical problems. To do other than this might result in needless exposure of many individuals to a potential carcinogen. □

NEW DRUG RESEARCH . . .

Ketipramine: Provided therapeutic effects equal to those of imipramine in the treatment of depressed patients; however, there were fewer side effects noted with ketipramine. The drug was administered to 8 patients in an average dose of 134 mg daily. By Dr. Sanghae Park and associates, of the New York University Medical Center, NYC.—AMERICAN DRUGGIST, Aug. 9, 1971 □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Professor of Clinical Pharmacology, Medical College of Wisconsin, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Drug Interactions

By Karl F. Ober, MD and Richard I. H. Wang, PhD, MD
Milwaukee, Wisconsin

It is common that many patients receive a variety of drugs during a particular illness. This concomitant intake of many compounds increases the probability of their incompatibilities within the patient's body. This phenomenon is commonly known as "drug interaction," which connotes an unpleasant and undesirable event. In reality, it is not necessarily deleterious. Deliberately planned interaction of drugs can provide very beneficial therapeutic results. For this reason, it is necessary for physicians to have some fundamental information and practical knowledge of drug interaction.

An overall view on drug interactions is best obtained by following the pathway of the drugs from their ingestion to their excretion according to the following outline.

I. Interactions at site of absorption

A. Alteration of absorption by the change of pH

Most drugs do not cross the lipoid mucosal membranes of the stomach or bowel wall by active transport mechanisms, but by diffusion. This latter process is governed by physicochemical laws. Nonionized drugs cross the protein–lipoid membranes easier. In the acid milieu of the stomach, all bases and many acids are found in the ionized form. The higher the pH of the stomach content becomes, the more acid drugs will become ionized. Hence, antacids will reduce the gastric absorption of acidic drugs like acetylsalicylic acid (aspirin), warfarin (Coumadin®), penicillins, and phenylbutazone (Butazolidin®). They will enhance the absorption of the basic drugs like amphetamine (Dexedrine®) or quinidine. It must be pointed out, that antacids can inhibit absorption of the other drugs by binding them or by influencing the gastric emptying. Theoretically, calculations with the pH of the various portions of the gastrointestinal tract and the pKa (dissociation constant) of the drug allow an exact determination of the absorbability of a particular substance. However, the clinical importance of drug interactions at the gastric site is of reduced importance, because most substances are absorbed in the duodenum and upper jejunum on account of the large surface areas.

B. Inhibition of the active transport mechanism

Folic acid, in small concentrations, is absorbed in the upper gastrointestinal tract by a specific enzyme-dependent transport mechanism, requiring also folate deconjugase. Its activity is inhibited by diphenylhydantoin (Dilantin®), primidone (Mysoline®), carbamazepine (Tegretol®), mephobarbital (Mebaral®), triamterene (Dyrenium®) and oral contraceptives.[1,2] Thus, the use of these drugs can reduce folic acid and may lead to mild megaloblastic anemia.

II. Interaction at protein-binding site

A. Competition for protein-binding site

After absorption, most drugs are bound to globulin or albumin or both. Protein-bound drugs are generally considered to be inert. As drugs compete with each other for the protein-binding sites, some are activated by being released from their protein-binding sites. Phenylbutazone (Butazolidin®) and salicylates reduce the binding of warfarin to albumin and thus lead to a prolonged prothrombin time and possibly bleeding.[3] Pyrazolone derivatives (oxyphen-

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Editor's Note: Many drugs have several trade names. In this article the generic name is usually followed by the most familiar trade name in parenthesis. Many drugs occur in combinations, the names of which do not allow the recognition of the individual components. If a drug is prescribed mainly by generic name, like digitoxin, no trade names are mentioned.

butazone [Tandearil®] and antipyrine) and salicylates also displace sulfonylurea derivatives such as tolbutamide (Orinase®) from their protein-binding sites, thus increasing the hypoglycemic effect of the sulfonylureas.[4]

Occasionally, drug interactions can be controversial and might not be explained by one mechanism alone. An example with some practical implication is the warfarin (Coumadin®) or bishydroxycoumarin (Dicumarol®) interaction with chloral hydrate. Following a case report by Cucinell and others,[5] it was thought that chloral hydrate, like certain barbiturates shortened the half-life of bishydroxycoumarin by enzyme induction. Contradictory results were obtained in studies by Sellers and Koch–Weser,[6] who showed that an enhancement of the warfarin effect took place when usual hypnotic doses of chloral hydrate (1 gm/day for 1 week) were given concomitantly with warfarin. They concluded that this increased activity was due to the displacement of warfarin from serum albumin-binding sites by trichloracetic acid, a metabolite of chloral hydrate. To make the matter more confusing, Griner and co-workers,[7] recently claimed no clinical significance, if not complete absence of warfarin and chloral hydrate interaction. Thus, more work is needed to clarify this important problem.

B. Increase of serum protein levels

A few drugs can elevate the serum level of specific proteins and thus lead to increased binding. For example, estrogens, especially estradiol, inhibit the liver metabolism of proteins which bind and inactive gluco-corticosteroids and iodine.[2]

III. Interaction at end organ receptor site

Competition for the receptor site is one of several types of interaction of drugs occurring at the end organ. The competition can be either reversible or irreversible, depending upon the molecular stability or the degree of affinity of the substance for the receptor.

The following are a few of the numerous examples of drug interaction by competition for the receptors: adrenergic alpha blockers like phentolamine (Regitine®) and beta blockers like propranolol (Inderal®) reverse the effect of direct and indirect sympathomimetics. Parasympathomimetic drugs, such as bethanechol (Urecholine®) or pilocarpine, compete with atropine. Morphine and nalorphine compete for the same receptors in the central nervous system. Streptomycin, polymyxin, colistin, kanamycin, quinine, and neomycin have synergistic effects with nondepolarizing neuromuscular blockers like d-tubocurarine (Tubarine®).

Competition for a specific uptake mechanism into the end organ is not as well known. Tricyclic antidepressants compete with guanethidine (Ismelin®) for the active transport mechanism at the adrenergic nerve ending.[8] While desipramine (Norpramine®) is taken up, guanethidine stays outside of the adrenergic nerve ending and thus remains inactive. A long list of phenethylamine derivatives, including phenothiazines, antihistamines, and tricyclic antidepressants reverse the effect of guanidinium hypotensive agents, such as bethanidine, bretylium, guanethidine, and debrisoquine.

IV. Physiological antagonism

Another important type of drug interaction which takes place at the end organ is called physiological antagonism. This is produced by drugs acting on different kinds of receptors, thus leading to dissimilar pharmacological activities. The classical example for this type of interaction is that between epinephrine and histamine. Of practical importance is the reversal of the ionotropic effect of digitalis by either propranolol or quinidine. Neostigmine and physostigmine antagonize atropine by inhibiting acetylcholinesterase and creating levels of acetylcholine that might overcome the atropine block.

A subgroup of the physiological antagonism is the increased sensitivity of receptors that is created by reducing the physiological outflow of receptor occupying substances. This type of exaggerated antagonistic response is found with amphetamine and guanethidine. Within minutes, amphetamine reverses guanethidine-induced hypotension far above the preguanethidine level.[9]

V. Interaction by changing drug metabolism

A. Enzyme induction

Various hormones, drugs, insecticides, and carcinogens stimulate microsomal enzyme activity in the liver of animals. Most of the enzyme-inducing compounds are lipid soluble, but there is no apparent correlation between their chemical structure and their ability to induce enzyme activity. The increased enzyme activity becomes evident at 3 to 5 days after the administration of the drug and the degree of enzyme induction is dose related. The increased enzymatic activity can last for months possibly because of storage of the stimulating drugs in body fat. Most of the research on this problem has been done in animals and one of the important findings was that there is a marked species difference making it difficult to apply many results of animal experiments to humans.[10] However, it can be assumed from human studies that phenobarbital (Luminal®), chloral hydrate, ethchlorvynol (Placidyl®), glutethimide (Doriden®), meprobamate and griseofulvin induce enzyme activity and thus increase the breakdown of other concomitantly administered drugs.[10]

It should be pointed out that an increased metabolism of a drug might lead to decreased or increased drug action. Decreased activity simply results from more rapid detoxification. But, if a metabolite has

more activity than the parent drug, enzyme induction can enhance the drug action.

B. Enzyme inhibition or substrate competition

Drugs can inhibit enzyme activity or compete with substrates for the same enzyme. Trichlorethanol, a metabolite of chloral hydrate, competes with alcohol for liver alcohol dehydrogenase and thus each interferes with the metabolism of the other. An example of enzyme inhibition is the hypertensive effect of tyramine (found in certain cheese, wine, and beer) on patients receiving monoamine oxidase inhibitors. Other examples of this type of antagonism are the inhibition of ethylbiscoumacetate metabolism by methylphenidate (Ritalin®), the inhibition of the metabolism of diphenylhydantoin (Dilantin®) and tolbutamide (Orinase®) by bishydroxycoumarin (Dicumarol®) and the inhibition of the metabolism of tolbutamide by phenylbutazone (Butazolidin®).[11]

VI. Interactions at site of excretion

A. Nonspecific

As described earlier, the absorption of drugs is influenced by the dissociation constant (pKa) of the drug and the pH of the surrounding milieu. The excretion of drugs is influenced in a similar way. Ionized, water-soluble substances which have filtered through the glomerulus diffuse less easily back into the blood than the nonionized drug. Thus, the rate of excretion of drugs depends partly upon the pH of the glomerular filtrate.

This type of interaction is specifically applied in situations where more rapid excretion of alkaline drugs such as amphetamines is desired by acidifying the urine with NH_4Cl or ascorbic acid, and long-acting barbiturates are more rapidly excreted by keeping the urine alkaline with sodium bicarbonate.

It should be mentioned that some drugs tend to crystallize in the nephrons under the influence of the pH of the glomerular filtrate. For example, the concomitant administration of sulfadiazine and any acidic drug like aspirin might lead to the tubular formation of sulfadiazine crystals and renal damage.

B. Specific

There are specific tubular transport mechanisms for acids and bases. Acids and bases use these specific transport mechanisms for secretion as well as reabsorption. The administration of probenecid, for example, inhibits the excretion of penicillin. The concomitant administration of quinine and morphine might reduce the excretion of morphine.

VII. Summary

In summary one can say that drug interactions are a rather complex problem. They can take place at different sites and result in an increase, a decrease or a neutralization of the effect of at least one of the given substances. Most drug interactions create no life-threatening situations. The few that have to be taken into consideration are those between monoamine oxidase inhibitors and sympathomimetics or tyramine, the prolonged prothrombin time after discontinuation of phenobarbital and other enzyme-inducing drugs in patients that concomitantly receive anticoagulants. However, much further work needs to be done to establish the clinical importance of many results of investigations made in animals.

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Open Lung Biopsy in Infants and Children

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Open lung biopsy through a limited thoracotomy was used in eleven selected infants and children during three years 1967 through 1970. Indication for biopsy was not only for chronic undiagnosed lung disease but also to accurately confirm suspected serious pulmonary disorders. Adequate lung tissue was obtained in all patients without significant morbidity and without mortality. The variety of diagnoses in our patients include Aspergillus pneumonitis, pulmonary blastomycosis, methotrexate pneumonitis, Farmer's lung, pulmonary allergic granulomatosis, Hamman–Rich interstitial fibrosis, idiopathic neonatal pulmonary fibrosis, interstitial pneumonia due to diffuse lupus erythematosus and chronic bronchitis and bronchiolitis. In seven of these eleven patients biopsy revealed a specific diagnosis. The technique permits thoroughly accurate diagnosis and treatment. □

Oxygen Therapy in the Newborn Infant

A STATEMENT OF THE COMMITTEE ON FETUS AND NEWBORN AMERICAN ACADEMY OF PEDIATRICS

The following recommendations will appear in the revision of the manual, Standards and Recommendations for Hospital Care of Newborn Infants, *scheduled for publication in 1971. Because the Committee felt a sense of urgency to provide these recommendations to pediatricians, family physicians, and other health professionals caring for newborn infants, they are being published prior to appearance of the manual.*

When a newborn infant needs extra oxygen, it must be administered with great care because there is a causal relationship between a higher than normal oxygen tension in arterial blood (60 to 100 mm Hg) and retrolental fibroplasia (retinopathy of prematurity). When the normal O_2 tension is exceeded, there is an increased risk of retrolental fibroplasia. The upper limit of arterial oxygen tension and its duration which are safe for these infants is not known. It is probable that even concentrations of 40% of inspired oxygen (formerly considered safe) could be dangerous for some infants.

An inspired oxygen concentration of 40% may be insufficient for infants with cardiorespiratory disease to raise the oxygen tension of arterial blood to a normal level. In such instances, an inspired oxygen concentration of 60%, 80%, or higher may be necessary. However, it is difficult to judge the concentration of inspired oxygen necessary to maintain effective oxygenation of tissues by clinical signs in these infants. An infant may have peripheral cyanosis and yet may have a normal or an elevated arterial oxygen tension. Therefore, arterial blood gas measurements are extremely important for regulation of the concentration of inspired oxygen when an oxygen-enriched environment is necessary.

Recommendations

1. Oxygen tension of arterial blood should not exceed 100 mm Hg and should be maintained between 60 to 80 mm Hg.
2. Inspired oxygen may be needed in relatively high concentrations to maintain the arterial oxygen tension in the normal range.
3. If blood gas measurements are not available, a mature infant who is not apneic but has generalized cyanosis may be given oxygen in a concentration just high enough to abolish the cyanosis. However, if supplemental oxygen is necessary for an immature infant, he should be transferred to a center at which inspired oxygen concentration can be regulated on the basis of blood gas measurements.
4. The ideal sampling sites for arterial oxygen tension studies are the radial or temporal arteries. In most circumstances, however, a sample from the descending aorta through an indwelling umbilical arterial catheter is satisfactory.
5. Equipment for the regulation of oxygen concentration (as provided by some incubators and respirators) and devices for mixing oxygen and room air may not function properly; therefore, it is essential that, when an infant is placed in an oxygen-enriched environment, the concentration of oxygen be measured with an oxygen analyzer at least every two hours. The performance of the oxygen analyzer must be checked daily by calibration with room air and 100% oxygen.
6. Mixtures of oxygen and room air may be delivered to an infant by endotracheal tubes, masks, funnels, hoods, or incubators. Regardless of the method used, the mixture should be warmed and humidified.
7. The condition of infants requiring oxygen may improve rapidly. Under these circumstances, the inspired oxygen concentrations should be promptly lowered. If the infant's recovery is gradual, the oxygen concentration should be lowered by 10% decrements, guided by blood gas measurements.
8. It should be appreciated that oxygen is toxic to other organs (e.g., lungs), which may be damaged even if the foregoing criteria are adhered to.
9. A person experienced in recognizing retrolental fibroplasia (retinopathy of prematurity) should examine the eyes of all infants born at less than 36 weeks' gestation or weighing less than 2,000 gm (4.2 lb) who have received oxygen therapy. This examination should be made at discharge from the nursery and at three to six months of age. □

A Wisconsin physician, Stanley N. Graven, MD of Madison, is a member of the Committee on Fetus and Newborn. Doctor Graven is Director of the Wisconsin Newborn Center, St. Mary's Medical Center, and Associate Professor of Pediatrics, University of Wisconsin Medical School.

Isocyanate Anhelation

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Isocyanates are widely used in the manufacture of urethane foams, varnishes, and furniture. Workers exposed to the irritating vapors of isocyanates often develop asthmatic bronchitis; a few may become sensitized. The latter express such dyspnea as bronchial asthma. The differential diagnosis may include other dyspneic states. Five patients with isocyanate anhelation are described presenting as bronchial asthma, asthmatic bronchitis, cardiac asthma, acute bronchitis with chronic obstructive lung disease, and hyperventilation syndrome. Careful medical inquiry will allow the recognition of isocyanate anhelation as well as the identification of those persons who are sensitized or becoming so. □

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MEDIASTINOSCOPY

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MEDIASTINOSCOPY WAS FIRST introduced by Carlens in 1959[1] as an additional procedure in the diagnosis of intrathoracic disease—both of pulmonary and mediastinal origin. Prior to that time, Daniels,[2] in 1949, had introduced scalene node biopsy for the detection of extra-thoracic spread of lung tumors and other systemic or thoracic lesions, and this was furthered in 1954 by Dwight Harken[3] who advocated upper and lateral cervical mediastinal exploration through a laryngoscope. The latter approach did not gain wide acceptance for fear of injury to the subclavian vein utilizing blunt dissection, and it remained for Carlens to develop the midline pretracheal approach. Although introduced 12 years ago, mediastinoscopy only recently has gained wider acceptance and application in this country.

Suprasternal mediastinoscopy gains access to the middle and posterior parts of the superior mediastinum with minimal surgical trauma. There is a definite anatomic basis since pulmonary lymphatics drain to the subcarinal and paratracheal areas and then up along the side of the trachea to the supraclavicular area.[4,5] Mediastinoscopy has the advantage of detecting early lymphatic spread and the operability of pulmonary malignancies. Therefore, this procedure may well eliminate the unnecessary "exploratory thoracotomy and biopsy" which in itself carries a significant morbidity and mortality.

Procedure. Mediastinoscopy is frequently combined with bronchoscopy and scalene node biopsy under the same general anesthetic, an economy of time for both the patient and doctor. These procedures may be performed under local anesthesia; (however, we prefer general). Bronchoscopy is recommended as the initial step as the findings may obviate the need for mediastinoscopy. The scalene nodes can be dissected through the same incision. With the patient in the supine position, the neck is slightly hyperextended over a pillow placed beneath his shoulders. The surgeon can work from the head of the table or the patient's side. Through a curvilinear 3–4 cm incision in the suprasternal notch, the skin and platysma are divided. At this point, the skin incision may be moved laterally to the right or left and a scalene node dissection performed between the heads of the sternocleidomastoid. If this is not desired or if the scalene node biopsy is unproductive, dissection proceeds by separating the strap muscles longitudinally, dividing the fascial layer between them. Dissection continues through the pretracheal fascia—for if this is not divided the substernal tunnel will be made in the wrong plane and the innominate vein and great vessels may be injured. The dissection is then carried beneath the pretracheal fascia along the anterior surface of the trachea to the carina—bluntly with the finger. Palpation gives valuable information about the area inferior to the major vessels anteriorly (not an area to be biopsied) and the consistency of the upper lobe take off. The mediastinoscope is then introduced behind the pretracheal fascia in the already made tunnel and advance. Each side of the trachea, the carina, and the right and left main stem bronchi for about 3 cm are inspected. The subcarinal region and proximal portions of each bronchus can be freed from the areolar tissue by blunt dissection with a long biopsy or dissection forceps. Lymph nodes or tumors at the tracheobronchial angles, subcarinal group, and in the paratracheal area can be

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TABLE 1: *Pathology of Positive Mediastinoscopies in 62 Patients*

Malignant		50
Squamous Cell	39	
Adenocarcinoma	4	
Oat Cell	2	
Lymphoma Hodgkin's	4	
Malignant Mesothelioma	1	
Benign		12
Sarcoid	9	
Histoplasmosis	2	
Wegener's Granuloma	1	
Tuberculosis	0	

biopsied. Fixation of tumor in the mediastinum or extension through the bronchial wall can be assessed. Prior to actual biopsy, a needle aspiration can be performed to rule out a vascular structure; this is important since in one's early experience a tangential view of a vein and a lymph node may be confused. After obtaining adequate specimens and ascertaining that adequate hemostasis exists (Bovie coagulation is helpful), the scope is withdrawn and the incision closed in layers with or without drainage.

Discussion. The indications for mediastinoscopy include:

(1) To establish a diagnosis of intrathoracic lesions preceding thoracotomy. This includes malignant and nonmalignant disease in which there is an enlarged hilum such as lymphoma, sarcoid, histoplasmosis, and other granulomatous disease, as well as bronchogenic carcinoma.

(2) To help establish resectability in known cases of carcinoma. This has been helpful in peripheral lesions greater than 2.5 cm in diameter or with hilar enlargement in established diagnosis by sputum or brush.

(3) For tissue diagnosis in lesions believed to be unresectable or in patients whose pulmonary function will not allow resection; these patients then may be treated with radiation and/or chemotherapy.

(4) To help establish resectability in cases of esophageal carcinoma.

(5) To replace atrial pacemakers—(this has been reported by Carlens although we have had no personal experience with this procedure.)

(6) Drainage of mediastinal abscess—tuberculous or otherwise. In one of our patients (RM) the esophagus was perforated because landmarks were lost and the patient was returned to the operating room 24 hours later and drained via the already made substernal tunnel under the pretracheal fascia.

Relative contraindications to mediastinoscopy include the superior vena caval syndrome with enlarged venous channels under significant pressure. Although some authors have reported performing

TABLE 2: *Reasons for No Exploration in 29 Patients with Negative Mediastinoscopies*

Poor pulmonary function and poor surgical risk	14
Distant metastasis	9
Malignant pleural effusion	2
Recurrent nerve involvement	3
Esophageal carcinoma with block	0
Azygous vein	1
	29

this procedure in the face of a superior vena caval syndrome, our early experience includes several aborted efforts in the face of annoying oozing where it was felt unsafe to bluntly dissect the substernal tunnel. In these cases, we employ the anterior parasternal mediastinotomy. Other relative contraindications are marked tracheal deviation with distortion of anatomic landmarks and in patients who have had previous laryngectomy with permanent tracheostomy.

The risks of mediastinoscopy in terms of morbidity and mortality are amazingly low. In reviewing over 15 reports in the literature including 4,000 cases the incidence of complications was less than 1% which included isolated reports of excessive bleeding, recurrent nerve paralysis (either permanent or temporary), pneumothorax, esophageal perforation, subcutaneous emphysema, mediastinitis, wound infection and chylothorax.

Our series dates back to late 1965 and includes 139 cases. Many of these were performed in conjunction with bronchoscopy and scalene node biopsy while others were performed immediately prior to scheduled thoracotomy; the latter combination adding approximately 45 minutes to our operating time. A positive diagnosis was established in 45% with malignancy diagnosed in 36% of the cases (Table 1). This diagnostic yield is comparable to other series for patients with known carcinoma of the lung which vary from 35% to 80%. Of the 77 patients with negative mediastinoscopy 29 were not explored; 14 were considered too poor a risk for thoracotomy and had poor pulmonary function, 9 had distant metastasis (mediastinoscopy was done to establish a tissue diagnosis), 2 had malignant pleural effusion, 3 had recurrent nerve paralysis (Table 2). Of the 48 patients who were explored, 35 had resectable lesions and 13 were unresectable (Table 3). The reasons for nonresectability include fixation in the hilum and to the pulmonary artery in 6, pleural and chest wall involvement in 3, superior caval involvement without clinical obstruction in 1, lymphosarcoma 1, diffuse disease in 1 and diffuse papillary carcinoma in 1. Of the 35 resected, 30 had no mediastinal nodes and 3 had positive nodes.

In this series there have been 4 complications (Table 4). The esophagus has been perforated twice, at or below the carinal level. I have alluded to one case in which there was marked salivary

Table 3: *Bronchogenic Carcinoma with Negative Mediastinoscopy in 48 Patients*

RESECTED		35	(73%)
Without positive nodes	30		
With positive nodes	3		
NOT RESECTED		13	(27%)
Pleural and chest wall metastasis	3		
Mediastinal extension	6		(4 in the LUL)
SVC involvement	1		
Diffuse disease	1		
Lymphosarcoma	1		
Papillary carcinoma of thyroid on biopsy	1		

Table 4: *Complications in 139 Cases*

Pneumothorax	2
Esophageal Perforation	2
Hoarseness—temporary	1

drainage noted on the dressing and the patient was returned to the operating room where adequate drainage was established through the already made substernal tunnel. This fistula closed spontaneously and the patient subsequently had x-ray therapy for bronchogenic carcinoma. The other case was detected on frozen section examination showing squamous epithelium and smooth muscle wall. The patient had a middle lobe mass on the right side and therefore underwent immediate thoracotomy, closure of the esophageal perforation, and lower and middle lobectomy on the right side. He made an uneventful recovery. Two cases of pneumothorax were noted. One required intercostal tube drainage, the other patient was observed.

There is some difference of opinion on what constitutes nonresectability in patients with lung cancer. When a positive mediastinal biopsy is out of the surgical field, the resection is palliative. We all know the disheartening results of palliative resections. Therefore, in patients with direct mediastinal tumor invasion, high lying positive adherent paratracheal nodes, and contralateral mediastinal spread, resection is not indicated. Patients with positive lobar nodes but negative subcarinal or tracheal nodes are clearly surgical candidates. There is controversy with respect to the subcarinal nodes—this may indicate the need for an extended pneumonectomy. Therefore, resection should be withheld from those patients who could not lose this functioning tissue, or who have an undifferentiated lesion or oat-cell type tumor.

Obviously, the patient's age, general status, pulmonary and cardiovascular reserve, and tumor cell type are but only some factors which influence the decision. Occasionally, palliative resections are mandatory for uncontrolled hemorrhage or obstructed infection. Mediastinoscopy as an adjunct in the diagnosis of intrathoracic disease has reduced exploratory thoracotomy by 30% to 40% and conversely the resectability rate has risen to 85% and 90%.[6,7] We have discussed the historical background, technique, indications, complications of this operative procedure, and presented our series in the hopes that this procedure will enable us to further reduce the morbidity and mortality of the exploratory thoracotomy and biopsy in those unfortunate patients with unresectable bronchogenic carcinoma. Utilized in combination with azygography and pulmonary arteriography, mediastinoscopy can yield much information about the status of the pulmonary hila. Mediastinoscopy can also be utilized for diagnosis of benign and malignant hilar lesions and drainage of mediastinal abscesses.

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Where Is Allergic Reaction in Ragweed Asthma?

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As ragweed pollen grains are 20 μ in diameter and too large to penetrate into the bronchi, it is conceivable that an allergic reaction in the nose might cause asthma through reflex or other mechanisms. Eight patients with ragweed asthma were challenged by direct application to the nasal mucosa of solutions of increasing concentrations of histamine and, on another day, of increasing amounts of dry ragweed pollen. One to 20 mg of histamine was required to produce sneezing, rhinorrhea, and nasal stuffiness, but a drop in FEV_1 was not observed in any subject. Pollen grains applied directly to the nasal mucosa provoked severe hay fever, but doses up to 1,500 grains did not cause a drop in FEV_1. On the other hand, inhalation of 100 to 500 grains through the mouth on a different day did provoke coughing and a 20 percent drop in FEV_1. Up to 5,000 grains placed on the posterior third of the tongue provoked drop in FEV_1 in 2 of the 8 patients. We conclude that ragweed asthma is not initiated by an allergic reaction in the nose. If obstruction of small airways arises through reflex mechanisms, the sensory arc of this reflex originates below the oropharynx. □

Complications of Cardiac Catheterization

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TWELVE YEARS AFTER the introduction of cardiac catheterization into clinical use a committee of the American Heart Association surveyed and reported on its complications in man.[1] This study, which included almost exclusively right heart catheterization, indicated a very low risk from the procedure. Although there were several other less extensive studies, no new major study appeared until the report in 1968 of a cooperative study on cardiac catheterization.[2] In this prospective study 16 cooperating laboratories pooled all of their data for a two-year period when records were carefully kept on more than 12,000 consecutive cardiac catheterizations. This study included right and left heart catheterizations as well as coronary arteriography.

It is recognized that the laboratories selected for this study may not have been representative of a cross section of cardiac catheterization laboratories throughout the United States since they were predominantly from teaching institutions or large clinics. In training centers where large numbers of procedures are done, there tends to be much variation in the experience of those involved in cardiac catheterization. On the other hand where few procedures are done, although the director is usually fully trained, there is difficulty in maintaining a competent team. Therefore it would be difficult to say whether the experience with complications garnered in this cooperative study is better or worse than that which one might expect from the country as a whole. In the absence of any other real body of data, that collected in this study is the best which is available.

Complications of cardiac catheterization may be classed etiologically into six groups as listed in Table 1.

Under *personnel failure* there are a wide variety of mishaps caused by members of the supportive team in the catheterization laboratory who have not done their job properly. These vary from infections and febrile reactions due to improper cleaning and/or sterilization of equipment, through inadvertent erroneous mixing of solutions, and wrong medications, to incorrect diagnostic determinations in which pressure recordings for example may be off by several fold. Such errors may cause anything from a minor annoyance to the death of the patient.

Under *equipment failure* there are again innumerable possibilities for difficulty. These may display the complete spectrum from the loss of part or all of the records or the cineangiograms which are presumed to have been obtained, through rupturing of support mechanisms on major pieces of equipment so that they fall on and severely injure the subject under study.

Similarly *physician failure* may occur at any point from the beginning to the end of the procedure. Thus the entire procedure may become impossible because the only available vein is damaged or destroyed. Improper collection of specimens may vitiate conclusions, or pressure may be recorded in the wrong areas without realizing that an error is being made. Thus the right and left ventricle overlie one another in the antero-posterior projection and may easily be confused by the unwary. Indeed the critical study required to clarify the diagnosis may not be done because the nature of the problem is not recognized. It is surely true that the collection of bad data is worse than collecting none because it gives an aura of scientific exactness which misleads rather than helps.

Patient failure may severely affect catheterization results in that, due to emotional upheaval, nonrepresentative data may be obtained. Indeed cooperation may fail to the point where certain critical information cannot be obtained or the procedure may have to be terminated. A sudden cough at the wrong time may impale the atrial wall or aortic root on a transseptal needle causing its perforation with resulting cardiac tamponade, and this may be fatal.

TABLE 1—*Classification of Complication by Etiology*

1. Personnel failure	4. Patient failure
2. Equipment failure	5. Mixed failure
3. Physician failure	6. Patient's disease

Probably most failures in cardiac catheterization will fall under the category of *mixed failure* in which multiple factors are involved and the blame cannot clearly be laid to any one single cause.

In a certain number of procedures as a direct result of complications of the *patient's disease,* disaster will strike. This may or may not be related to the procedure itself. As an example, a patient with coronary artery disease may develop myocardial infarction and die at any time, including that time which he spends undergoing a cardiac catheterization, and the final event may or may not be related to what

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TABLE 2— *Serious Complications of Cardiac Catheterization*

1. Death	7. Infections
2. Arrhythmia	8. Allergic Reactions
3. Profound Hypotension	9. Embolism
4. Arterial Complication	10. Cardiac Complications
5. Cardiac Perforation	11. Bleeding
6. Catheter Problems (knotting, breaking, etc.)	12. Pneumothorax
	13. Other

is going on about him at the time. A patient who has had multiple cardiac arrests may arrest again during pacemaker insertion and it may not be possible to revive him through no fault of the catheterization team.

In general, the more experienced and skilled the individual in charge of the catheterization, the better trained team, the more adequate the equipment, and the more cooperative the patient, the better the result will be, the more information will be obtained and the more clearly all facets of the problem will be defined.

In the cooperative survey of complication of cardiac catheterization major complications occurred in 3.6% of 12,367 catheterizations. Death of the subject accounted for 0.44% of these complications, and the others are listed in Table 2. It should be realized that this list was agreed upon by a committee of very knowledgeable cardiologists, and complications were included only if they were considered to be seriously threatening to the welfare of the patient. Indeed if these complications are managed improperly they could frequently result in serious disability or even death of the patient. It was apparent from the report that the complication rate among babies was very significantly greater than that in other age groups with a death rate of about 6% in those from 0–60 days of age. It was also clear that many deaths in this young age group were related to the severity of the disease for which the patient was studied. However, an attempt was made to exclude deaths which were not thought to be closely related etiologically to the catheterization procedure, and it must be recognized that many of these deaths were clearly attributable to the catheterization procedure. It also should be pointed out that the incidence of major complications was not significantly different (2.0%) in normal individuals who underwent cardiac catheterization as a postoperative study or who were catheterized for diagnosis of benign murmurs than it was in those who had clear organic cardiovascular disease (3.6%).

Although transseptal catheterization has been considered to be so dangerous that it has been abandoned in many laboratories, the incidence of major complications clearly caused by transseptal catheterization was essentially the same (3.4%) in the 1765 transseptal catheterizations as it was in the rest of the study involving over 12,000 procedures. This may well mean that those who did not learn to do the procedure well stopped after their first failures and those who continued to do the procedure gained sufficient experience that it became less dangerous in their hands. It may also mean that more transseptal punctures were done in those in the middle age groups where the complication rate is relatively low and that transseptal puncture does carry more risk than other procedures but is masked by the relatively good outlook of those in whom it is used. At any rate the published data do not justify the conclusion that this procedure is too dangerous to use routinely and the information which it permits one to obtain seems to me to justify its continued use, provided one is willing to learn the technique and use it frequently enough to remain skilled.

Complications of coronary arteriography were subdivided in this study into the data from one laboratory where the most coronary arteriograms were done and those done in all of the other laboratories in the study. There was a very significant difference between the complications in the most experienced laboratory and the rest reporting in this group. The overall incidence of complications was roughly 2% and of these ventricular fibrillation accounted for 0.7%. It is a tribute to the prompt and effective treatment of this catastrophe that there were no deaths from ventricular fibrillation. In five subjects myocardial infarction occurred, and it must be an accepted risk that this may occur during or after the procedure any time it is undertaken. Many additional complications are known to occur such as: (1) cardiac arrest, (2) cardiac perforation, (3) coronary artery dissection, (4) severe hypotension, (5) aortic valve damage, (6) brachiocephalic arterial damage, and (7) stroke.

Summary

Cardiac catheterization is a potentially dangerous procedure which may result in loss of life, limb, brain, or of almost any other organ. It should not be undertaken lightly, nor should it be done unless the information to be obtained is specifically useful for the patient on whom the study is done. All physicians and their patients should know this before catheterization is undertaken and no one should be misled by ill founded claims to the contrary. The tendency of some to minimize the significance of the risk is ill advised and can lead to great difficulty with the startled and disbelieving surviving relatives. Properly done, cardiac catheterization furnishes information which cannot be obtained any other way and helps to insure that the proper treatment is given with reduced risk. Its use is especially great as a preoperative guide to the surgeon, but it should be realized that with catheterization as with everything else, one never gets something for nothing.

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Familial Multiple Polyposis: A "Curable" Disease

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FAMILIAL MULTIPLE POLYPOSIS (FMP) is a heredito-familial disease characterized by autosomal dominant inheritance, polyposis coli, and a marked tendency for the development of colon carcinoma. Failure to recognize this disorder in afflicted individuals and to evaluate all family members often results in tragic death from widespread colon malignancy.

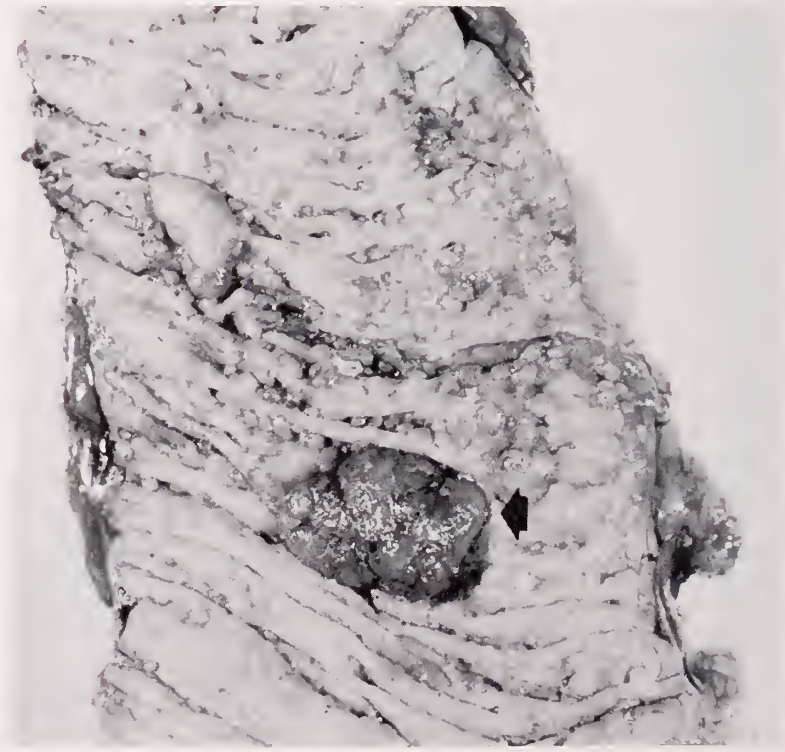
During the past year, we have evaluated 10 patients with FMP; 7 patients were from two afflicted families, and 3 patients represented sporadic cases. Two of the 10 patients had developed colon carcinoma before the nature of their disease was recognized; the remaining 8 did not have colon malignancy at the time of elective colectomy. Our experience emphasizes the fact that accurate diagnosis and appropriate treatment of FMP depend on thorough familiarization with the salient features of the disease.

Hereditary features. Familial multiple polyposis shows a Mendelian dominant pattern of inheritance. Consequently, about one-half the offspring of individuals with FMP will inherit the polyposis gene, and the sexes are equally affected. The incidence of FMP in this country has been estimated by two independent studies to be about 1 in 7000 to 8000 live births.[1, 2] Approximately two-thirds of afflicted individuals have a positive family history, whereas one-third represent sporadic cases.[3] The FMP gene has high penetrance, estimated to be about 80 percent.

Clinical features. Although the development of polyposis has been noted to occur during childhood, the polyps usually first appear at time of puberty. Occasionally, the polyps may develop for the first time in individuals older than 40 years of age. Onset of clinical symptoms generally occurs during the twenties or thirties, the average age being about 30 years.[3] Symptomatology tends to occur earlier in sporadic than familial cases. Symptoms include vague abdominal pain or discomfort, diarrhea, bloody stool, weight loss or prolapse of a polyp through the rectum. Occasionally, the disorder is associated with protein-losing enteropathy, resulting in hypoproteinemia. Many individuals with clinical symptomatology have an existing colon carcinoma or develop a large bowel malignancy within two years.[3] Virtually 100 percent of untreated patients develop large bowel carcinoma. The carcinoma arises about 15 years after the onset of polyposis, and the average age of death from colon malignancy is 40 years.[4]

Pathology. The gastrointestinal polyps are numerous, range from pin head lesions to 1 cm or more in size, and may be sessile or pedunculated (Fig 1). Involvement of the rectum and left colon is more frequent than of the right colon, but often the entire co-

Fig. 1—Colon specimen resected from a 40-year-old man. Myriads of 1 to 2 mm adenomatous polyps are present. A 1.5 x 2 cm adenocarcinoma (arrow), located in the ascending colon, is clearly seen.



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lonic mucosa is carpeted with myriads of polyps so that normal mucosa is not seen. Involvement of the small bowel or stomach, or both, occurs in less than 5 percent of FMP patients. On histologic examination, the polyps are indistinguishable from solitary adenomatous polyps in adults. Occasionally, villous adenomas or inflammatory polyps also may be present. Frequently, multiple carcinomas in different stages of development are in evidence.

Diagnosis. Sigmoidoscopy is an excellent screening technique for identifying patients with polyposis coli because the polyps are almost always present in the rectum.[5] Although roentgenographic examination of the colon seldom demonstrates polyps when sigmoidoscopy yields normal findings, a colon examination should be performed in all suspected FMP patients in order to document the size, number, and distribution of polyps. On barium enema examination, the polyps may be seen as multiple punctate nodules which impart a serrated contour to the intraluminal barium column or as larger filling defects (Fig 2A). Small, elusive polyps, 1 to 2 mm in diameter, may be hidden by barium, but often are well shown on pneumocolon examination. Carcinomas, when present, appear as polypoid filling defects, segmental areas of narrowing, annular lesions with overhanging margins or fungating masses (Fig 2B).

Treatment. The colon is a dispensable organ, unnecessary for useful life. Colon carcinoma,

Fig. 2—Barium enema examination performed on a 38-year-old man.

(A) The numerous 5 to 10 mm filling defects, initially regarded as fecal material distributed throughout the colon, were shown on the resected surgical specimen to be multiple polyps. Irregularity of the right rectal contour (arrow) suggests the presence of a carcinoma.

(B) A spot roentgenogram of the rectum clearly demonstrates a large fungating carcinoma.

therefore, is entirely preventable in patients with FMP if the disease is diagnosed early and prophylactic colectomy performed. Generally, surgery can be safely deferred until the patients are in their late teens or early twenties. Proctocolectomy accompanied by ileostomy may be performed on some FMP patients, but colectomy with an ileorectal anastamosis is a suitable operation for reliable patients who will return for biannual follow-up proctoscopic examinations.[6] In some instances, the rectal polyps regress following colectomy.[7] Persistent or recurrent rectal polyps may be fulgurated by cautery.

Discussion. Because colon carcinoma invariably develops in untreated patients with familial multiple polyposis, the need for early and accurate diagnosis in affected individuals and subsequent family screening cannot be overemphasized. A high index of suspicion is necessary. Familial multiple polyposis should be suspected when one encounters individuals with more than one colon polyp or individuals with colon carcinoma who are less than 40 years of age. In the individual patient, familial multiple polyposis and its sequelae represent a potentially curable disease, provided the target organ (colon) is resected before the occurrence of metastatic colon carcinoma. Treated patients, however, obviously retain the capacity to transmit the polyposis gene to their children.

Familial multiple polyposis represents a human model of colonic neoplasia from which information about the pathogenesis of colon carcinoma may be gained. We anticipate that histologic examination and tissue culture studies performed on serial biopsy material taken from rectal polyps, and normal appearing rectal mucosa of FMP patients will reveal significant features concerning large bowel malignancy.

The relationship between familial multiple polyposis and other polyposis coli syndromes, such as Gardner's syndrome, remains obscure. McKusick has suggested that the respective genes causing familial multiple polyposis and Gardner's syndrome may be alleles occurring at the same chromosomal locus.[8] Smith hypothesizes that familial multiple polyposis and Gardner's syndrome represent opposite poles of a disease spectrum caused by a single pleotrophic gene with varying expressivity.[9] Genetic linkage studies may provide answers to some of these questions. The data from our own investigation is not yet sufficient to permit conclusions about linkage relationships, and more families are needed for study.

Summary. Colon carcinoma, which inevitably develops in individuals with familial multiple polyposis, is preventable via prophylactic colectomy. Consequently, the need for accurate and early diagnosis of familial multiple polyposis cannot be overstressed. The salient features of this disease entity are reviewed.

ACKNOWLEDGMENT: The authors wish to thank the following physicians for providing case material: George F. Unger, MD; John Opitz, MD; Albert A. Nemcek, MD, and John D. Riesch, MD.

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Bone Marrow Transplantation for Aplastic Anemia

M M BORTIN, MD, EDWARD C SALTZSTEIN, MD, BURTON A WAISBREN, MD, SHERMAN A KAY, MD, RICHARD HONG, MD, and FRITZ H BACH, MD, Mount Sinai Medical Center, Milwaukee, Wis: *Transplantation* 11:573–575 (June) 1971

A 33-year-old woman with aplastic anemia was treated with bone marrow transplantation after conventional therapy failed. Three HL-A identical siblings were used as donors. Large doses of cyclophosphamide provided sufficient immunosuppression to permit engraftment of allogeneic marrow but may have contributed to the patient's death by causing myocardial necrosis. Bone marrow from the male donors was given I-P and successful engraftment was demonstrated by finding XY chromosomes in the marrow of the recipient 14, 21, and 27 days post-transplant. Successful engraftment of I-V administered bone marrow cells from the female donor was proved by finding donor-type XO chromosomes in the patient's marrow. The patient exhibited a progressive rise in peripheral blood leukocytes starting 23 days after bone marrow transplantation. She died suddenly of myocardial necrosis, interstitial pneumonitis and pulmonary edema 27 days after grafting. Death was probably due to an overwhelming herpes simplex (type I) virus infection. □

COMMENTS ON TREATMENT

Presented monthly, except January and December, through the cooperation of the Departments of Pharmacology and Medicine, Medical College of Wisconsin, Milwaukee, and the Department of Medicine, University of Wisconsin Medical School, Madison

Co-Editors: RICHARD I. H. WANG, PhD, MD, Professor of Clinical Pharmacology, Medical College of Wisconsin, Milwaukee; and OVID O. MEYER, MD, Professor of Medicine, University of Wisconsin Medical School, Madison

Treatment of Carcinoma of the Esophagus

By John R. Pellett, MD
Madison, Wisconsin

CANCER OF THE ESOPHAGUS continues to be a difficult and often times confusing problem for the involved physician. In spite of significant advances in surgical therapeutics, radiotherapy and chemotherapeutic techinques, the prognosis for the patient with this diagnosis has remained grim. The five-year survival has been reported as low as 1% to 6%. Some authors have labeled this problem a disaster.[1] The literature is replete with evidence of the tremendous difficulties and problems associated with selecting the proper mode of therapy depending on the original site and the degree of involvement at the time the patient is initially seen.

The first surgical attack by Czerny in 1877 opened a new era of management, but not until 1913 was the first successful resection of the thoracic portion of the esophagus reported.[2] This involved thoracic esophagectomy, cervical esophagostomy and gastrostomy. In 1933, resection of the intrathoracic portion of the esophagus with primary esophagogastrostomy was accomplished. Since the report by Adams and Phemister in 1938, surgery has been the treatment of choice for carcinoma of the thoracic esophagus. The results have been extremely disappointing. Influenced by the dismal results of this technique, increasing interest was shown by various investigators utilizing radiation therapy. Unfortunately no significant improvement in the survival of patients has resulted from the use of this modality alone. Stimulated by the work of Nakayama[3] in Japan, interest developed in combination therapy employing radiation and surgery, both in the preoperative period or following surgical resection. Various treatment plans are available utilizing conventional cobalt therapy with doses ranging from 4,000 to 6,000 r preoperatively over a four-to-six week course, to a three-day plan with a total dosage of 2,000 r given in divided doses. Complications with this short intense course were few in number. As one reviews the literature, an immediate sense of frustration evolves in attempting to correlate and establish a single plan of attack using available forms of therapy.

Dysphagia and weight loss are the most apparent symptoms noted by patients. Dysphagia is often not fully appreciated as the slowly progressing intensity of this symptom is often rationalized by the patient as being related to emotional problems or failure to properly chew his food. Unfortunately because of this progressive symptomatology, advanced stages of the disease are often present when the patient first consults his physician. Survival in the untreated patient may be only seven and a half months[4] after onset of symptoms but a more protracted course is usually seen. It is clearly evident that the best results should occur in patients with small localized lesions without evidence of adjacent spread to vital mediastinal structures, lymph node metastasis or distant spread.

Preoperative Management. Upon reviewing surgical experience with carcinoma of the esophagus, it would appear that therapy most often has been directed toward palliative measures. Two reasons seem responsible for this: (1) Extensive disease is present at the initial evaluation or is found at the time of surgical exploration, and (2) Inadequate resections are carried out in the apparent curative situation. It becomes necessary to subject patients to complete preoperative diagnostic studies in an attempt to spare the patient who has direct local invasion of vital mediastinal structures, distant lymph node metastasis or organ involvement, unnecessary surgical procedures. This helps to insure that the group of patients eligible for a cure receive the proper treatment.

The required studies include in addition to general medical evaluation, liver scan, barium esophogram and upper gastrointestinal series, barium enema, azygograms, esophagoscopy and bronchoscopy. Invasion of the trachea and bronchus is a contraindication to thoracotomy. Our plan of management, therefore, is dependent upon the clinical staging. Patients, who on esophagoscopy are found to have squamous cell carcinoma involving the intrathoracic

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portion of the esophagus and no obvious contraindications to surgery, are subjected to venous azygography. Our experience has revealed that an obstructive azygos venous system places these patients in a palliative group and therapy should be so directed.

Attempted Curative Procedures. In the presence of a normal venous azygogram several alternatives are available for the subsequent curative approach. It has been found repeatedly that squamous cell carcinoma not only spreads by direct extension to vital structures such as the aorta and the bronchi but also through the rich submucosal lymphatics as well as to the periesophageal lymphatics. This submucosal involvement can be extensive and in all probability accounts for the large number of recurrent lesions seen after limited esophagogastrectomy. It is our thought, therefore, that for squamous cell carcinoma of the thoracic esophagus, total esophagectomy is a must in the curative plan of management.

The difficulty from this point forward is deciding whether total esophagectomy should be step 1 followed at a later date by reconstruction as step 2, or reversing the sequences utilizing a segment of colon to bypass the lesion from stomach to cervical esophagus as step 1, finally performing total esophagectomy as step 2.

In our earlier experience with 16 patients who were all clinically resectable with no evidence of extrathoracic metastasis, our plan of attack was to explore the abdomen and neck and if no tumor was found in these areas to proceed with colon bypass from the stomach to the cervical esophagus. Twelve of these patients had microscopic evidence of tumor involving the lymph nodes in either the celiac or cervical area at the time of this initial bypass procedure and thus could be considered as being in the palliative group that would not benefit from total thoracic esophagectomy. For patients with a negative abdomen and neck, the theoretical disadvantage in this approach is that the tumor remains in place until the second stage resection is accomplished. We, therefore, did a small series of patients in whom abdominal and cervical exploration was accomplished. If no metastases were present, a gastrostomy was performed. The patient was then subjected to a radiation therapy followed in six weeks by total esophagectomy as a second stage with a subsequent third stage reconstruction utilizing the colon from the remaining stomach to the cervical esophagus. Although this treatment period is lengthy, requiring three months to complete, our long-term survivors of four to seven years have been in this group. It should be noted that in spite of 5,000 to 6,000 r delivered to the area, residual tumor was found in the resected specimens. Some patients may be reluctant to accept the three-stage plan involving radiation therapy, total esophagectomy with cervical esophagostomy, and the undesirable presence of a fistula in the neck for four to six weeks, followed by the reconstruction as a final third stage. Experience has demonstrated, in a collective review, an unacceptable high mortality rate of 50% from one-stage total esophagectomy and colon replacement.

We have attempted other forms of management such as mobilization of the stomach via laparotomy, proceeding, in the clinically negative abdomen, with a right thoracotomy and total thoracic esophagectomy, reconstructing intestinal continuity by high intrathoracic esophagogastrectomy. The submucosal lymphatic extensions of these lesions have been dramatically apparent and one can categorically state that the often times accepted procedure of left thoracotomy and esophagogastrectomy for squamous cell lesions of the lower one third of the esophagus is entirely inadequate therapy. Total thoracic esophagectomy with mediastinal dissection is accomplished more effectively by a right thoracic approach.

Palliative Procedures. Surgical procedures are available for consideration in the palliative situation. Colon bypass in selected cases has resulted in survival up to 27 months with no other therapy, but this is unusual. When the anticipated survival is less than six months, it is indeed difficult to justify a procedure of this magnitude. Endoprosthetic intubation employing the Celestin tube has become our recommended procedure when it is appropriate in the strictly palliative case. Lower one third lesions lend themselves best to this form of palliation. Patients are able to take liquids and pureed foods and handle their secretions adequately, thus delaying aspiration pneumonia, which is the usual immediate cause of death in malignant esophageal obstruction. Survival of more than one year may occur, depending upon the degree of metastatic involvement. Palliative esophagogastrectomy does not seem to offer the patient longer survival and certainly accounts for a greater morbidity and mortality than the simpler procedure of endoprosthetic intubation. High cervical esophageal lesions are most often treated by high dosage irradiation therapy. Gastrostomy provides a route for alimentation but offers no help in preventing aspiration pneumonia or relieving the patient's most distressing symptom, i.e., handling his secretions. Performing this procedure does allow the patient to manage himself somewhat better at home.

Long-term survivors are possible with this serious lesion if aggressive radiation therapy, radical thoracic esophagectomy, and colonic replacement of the esophagus are utilized. The alternative plan of colon bypass in the clearly operable patient followed by irradiation to the thoracic esophagus and subsequent radical esophagectomy can be accomplished. Too often physicians have felt that treatment of carcinoma of the esophagus is strictly palliative and less radical programs are often recommended. This should be discouraged. Early investigation of dysphagia, no matter how insignificant it may seem, by barium x-ray studies and direct inspection uti-

lizing the flexible esophagoscope and gastrocamera, is strongly urged and highly recommended. It is apparent that only by collecting enough experience in any of these treatment categories will one be able to finally determine the most effective means of handling the individual patient with his particular clinical situation.

Hopefully, by concentrating these cases at a medical center where a program of radical surgical resection, esophageal replacement, and radiotherapy are available, patients with this complex problem may be offered the greatest chance for long-term survival.

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SPECIAL NOTICE

Prenatal Antibody Screening and Use of Rh_0(D) Immune Globulin (Human)

THE ORIGINAL ANTIBODY described by Levine, Anti-Rh_0 (anti-D), accounts for many cases of hemolytic disease of the newborn, but antibodies to many other red cell antigens, such as c, K and JK^a, can also cause severe hemolytic disease by exactly the same mechanism elucidated for Rh factor. The Rh positive mother, like the Rh negative, may produce antibodies to any foreign red cell; anti-hr′ (c) anti-rh″ (E) and anti-K account for the majority of cases of hemolytic disease of the newborn in Rh positive women.

Prenatal testing (pooled red cell antigen) identifies those patients subject to high risk and alerts the physician to the presence of dangerous maternal antibodies. The identity of any irregular antibody discovered should be determined and its strength estimated by antiglobulin titrations. The identity and titer of the antibody would suggest whether or not amniocentesis should be performed.

Since clinical action now depends almost entirely on the results of spectrophotometric study of the products of sensitization found in the amniotic fluid, the role of antibody testing is to provide indications for performing amniocentesis.

Repeat Rh antibody titers are suggested for all Rh negative mothers at about the 28th and 35th weeks. Additional studies are indicated if the titer is significantly elevated.

Proper utilization of screening, identification of specific antibodies, titer determinations and amniocentesis, as well as postpartum treatment to prevent isoimmunization, will decrease the risks of hemolytic disease and improve perinatal survival.

Isoimmunization to the Rh factor may be prevented by passive immunization with Rh_0(D) immune globulin (human).

Rh_0(D) immune globulin (human) effectively prevents the formulation of active antibodies in the Rh negative mother who has aborted or delivered an Rh positive fetus. Rh_0(D) immune globulin (human) should be administered only to an unsensitized Rh(D) negative woman within 72 hours after abortion or after the delivery of an Rh_0(D) or D^u positive infant. When Rh_0(D) immune globulin (human) is to be administered to the postpartum patient the following criteria should be met:

Mother:

1. Mothers must be Rh_0(D) negative and D^u negative. (Rh Test)
2. Maternal serum must be free of Rh_0(D) antibody. (Antibody Screening Test)
3. Compatibility must be determined by cross-match with the mother's blood.

Baby:

4. Baby should be Rh_0(D) positive or D^u positive.
5. Baby's cord cells should be free of antibodies to Rh. (Direct Coombs Test—Negative)

The Direct Coombs Test of course may be positive and the baby's cells still free of Rh antibodies, the positive Coombs Test being due to some other antibody.

After each subsequent delivery of an Rh positive fetus or abortion, the unsensitized Rh negative mother should again be protected with Rh_0(D) immune globulin (human). This includes patients undergoing therapeutic abortion.

Procedure:

There are 72 hours available postpartum or following abortion for effective administration of Rh_0(D) immune globulin (human).

If an Rh determination was not made before admission, a tube of clotted blood should be sent to the blood bank without delay for the purpose of determining the Rh type and antibody screening.

When the patient is known to be Rh negative, unsensitized, and is admitted for delivery:

1. Draw 10cc of blood from the mother (clotted).
2. Send to blood bank for antibody screening. This will be used to determine sensitization and for cross matching with Rh_0(D) immune globulin (human).

Reprinted with permission from American College of Obstetricians and Gynecologists TECHNICAL BULLETIN, *Number 13, June 1970.*

A Survey of Students in a Medical School Cardiac Work Classification Unit: Implications for Vocational Health in Comprehensive Medicine

G A HELLMUTH, MD, Director, Cardiac Work Classification Unit, Milwaukee, Wis: *Arch Env Health* 22: 505–511 (April) 1971

A Cardiac Work Classification Unit (CWCU) is ideally suited for introducing medical students to the total patient care approach in the vocational restoration of cardiac patients. Using the multidiscipline team approach, it acquaints students with the medical, psychosocial and vocational aspects of comprehensive care and prepares them for this application in their respective medical practices.

The usefulness of a CWCU as a teaching and learning device was demonstrated from 1959 to 1967 when the CWCU was used as part of an accredited course by the Medical College of Wisconsin (formerly Marquette School of Medicine). All senior students participated in the unit on a rotation basis. They actively took part in patient evaluation and in making work potential recommendations.

To evaluate the success of the unit an opinion-research survey of a random sample of students who participated was undertaken from 1964–1966. The survey showed that the students gained an effective orientation in practical patient involvement and in the use of the multidiscipline method. The study concluded that in view of the current demands for physicians directed to comprehensive medicine, the shortage of physicians which would be relieved in part by the use of paramedical disciplines and the favorable results of our research survey of medical students who participated in the CWCU justify recommending that units be used in integrated medical undergraduate curricula. Units can demonstrate the pedagogic principles of the wholistic approach to patient care while offering the student a teaching and learning experience in the restoration of the cardiac worker. Exposure to cardiac patients with medical, psychosocial and vocational problems makes clear to the student that the knowledgeable new physician can make a most effective and far-reaching contribution to easing the plight of the cardiac worker and can help in relieving the community problem in the delivery of optimal cardiac rehabilitation. □

PRENATAL ANTIBODY SCREENING

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3. Send one tube of cord blood (clotted) for Direct Coombs Test and Rh determination.

Refusal of Treatment

There may be instances in which patients, after recommendation by their doctors, refuse rubella immunization or Rh_0 immune globulin (human).

The American College of Obstetricians and Gynecologists has developed a suggested form, with a space for signatures of patient, physician, and witness, which can be utilized when a candidate for immune globulin refuses authorization for treatment. It is reproduced on the opposite page with permission of the College.

The College's June 1971 Newsletter had this further comment:

"The danger of Rh sensitization with abortion is of growing importance. In view of the relaxation in some jurisdictions of laws governing abortion, physicians are urged to be cognizant of potential sensitization to Rh after six to eight weeks of gestation.

"In the case of rubella immunization, where no specific form for the purpose has been developed, a form which the patient can sign acknowledging refusal of immunization is adequate. The AMA's 'Medico-legal Forms—With Legal Analysis,' available from the AMA, has examples of consent and refusal of treatment forms designed for various purposes which can be used or adapted."

The January 1970 Blue Book issue of the *Wisconsin Medical Journal* also published examples of consent and refusal treatment forms.

Rh_0(D) immune globulin (human) will be dispensed by the blood bank for administration to the mother upon the prescription of the physician, provided all the criteria for this treatment have been met.

Ample time should be allowed the blood bank to complete the complex studies, within the allowable time limit for treatment.

Contraindications:

Rh_0(D) immune globulin (human) should *not* be administered to:

1. An Rh(D) positive or D^u positive individual.
2. One who has been previously sensitized to Rh(D).
3. One who has recently received an Rh(D) positive blood transfusion.

Cautions:

Rh_0(D) immune globulin (human) should be injected intramuscularly to the postpartum or postabortal patient. It must *not* be given to the infant.

Reactions of Rh(D) negative women to Rh_0(D) immune globulin (human) are generally mild and infrequent and mostly confined to the site of the injection.

An occasional patient may react more strongly both locally and generally. A slight elevation in temperature has been noted in a small number of cases.

Systemic reactions are rare, and sensitization due to repeated injection of immune serum globulin is unusual.

The administration of Rh_0(D) immune globulin (human) applies only to the prevention of sensitization by Rh_0(D) or D^u. The incidence of sensitization by other red cell antigens is so low, that the use of other specific antiglobulins is impractical.

ACKNOWLEDGMENT: The Committee on Technical Bulletins of the ACOG is grateful to Dr. William G. Slate of the Albert Einstein Medical Center, Philadelphia, for his assistance in preparing this information.

PATIENT IDENTIFICATION

Rh_0 (D) Immune Globulin

AUTHORIZATION AND PROCEDURE

AUTHORIZATION OF MOTHER

I understand that I am a possible candidate for Rh_0 (D) immune globulin; that the indications for this have been explained to me; and that my physician has advised that I accept this medication if it proves to be indicated.

☐ I authorize this medication, if indicated.

☐ After explanation, I refuse this medication.

PATIENT _____ PHYSICIAN _____

WITNESS _____ Date _____ MO. DAY YEAR

PROCEDURE (Complete only if authorized above)

1. DETERMINE MATERNAL ANTIBODY TITER AT TERM:

IF

POSITIVE TITER → NO FURTHER ACTION

NEGATIVE TITER → IF

PATERNITY FACTOR NEGATIVE → NO FURTHER ACTION

PATERNITY FACTOR POSITIVE → FURTHER ACTION

2. ☐ ABORTION OR MACERATED STILLBORN → Notify Blood Bank no baby blood to follow.

BABY:
At delivery draw **5 cc.** of cord blood (be certain that it is not contaminated with mother's blood running down outside of cord). Place in (clotted) tube and send (STAT) to Blood Bank, indicating clearly that this is **Baby's** blood.

MOTHER:
Draw **10 cc.** of mother's blood (clotted) and send (STAT) to Blood Bank with BLOOD BANK REQUEST signed by M.D., indicating clearly that this is the **Mother's** blood.

3. Received by Blood Blank:
Signature _____
Date: Time:

Received by Blood Blank:
Signature _____
Date: Time:

4. NOTIFIED BY BLOOD BANK
Date: Time:

☐ MOTHER IS **NOT** CANDIDATE FOR IMMUNE GLOBULIN
No further action, EXCEPT

☐ MOTHER **IS** CANDIDATE FOR IMMUNE GLOBULIN
IMMUNE GLOBULIN INDICATED. FURTHER ACTION

5. NOTIFY ATTENDING PHYSICIAN
Nurses' signature _____ Date: Time:

6. IMMUNIZATION GIVEN:
AMT.: DATE: TIME: SIGNATURE

MODIFIED AND REPRODUCED WITH PERMISSION OF AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

Cardiac Employees and Their Immediate Supervisors: Effects on Industrial Medical Programs

G A HELLMUTH, MD, Medical College of Wisconsin, Curative Workshop of Milwaukee, Milwaukee, Wis: *J Occup Med* 13:166-174 (April) 1971

Results of a survey of cardiac employees and their supervisors in a large, light manufacturing firm revealed that in an environment with cardiac-supervisor rapport and ideal conditions cardiacs can be effective workers. Factors in an ideal industrial environment are a competent in-plant medical program and the plant physicians' active participation in implementing management medical policy.

The plant surveyed had 8,500 employees. Ninety-three participants were interviewed, 60 as cardiac employees and 38 as supervisors. The taped interviews were then rated. The study showed that almost all cardiacs were satisfied with the way their supervisors treated them. The supervisors, in turn, expressed satisfaction over the work performance of cardiacs. Important reasons for the favorable reactions were the company's liberal policy toward individuals with handicaps, its ideal medical surveillance, the nature of its manufacturing, and its size.

The study showed that medical surveillance could be applied to improved cardiac employment in industry. A well managed medical department, such as the one surveyed, reduced physical barriers to cardiac employment and abated fear of cardiac workers based on incorrect adjudication of Workmen's Compensation claims. The participation of the plant's part-time knowledgeable physicians in company employment decisions also had an important effect on the company's liberal attitude toward hiring and rehiring cardiacs. □

A Medical Rarity

Siamese Twins

These Siamese twins were born at term, delivered by Cesarean section in Holy Family Hospital, Manitowoc, Oct. 11, 1953, by W. A. Rauch, MD. They lived for about an hour.

Doctor Rauch has offered the following information:

Siamese twins may present a problem in diagnosis in twin pregnancy. In this case x-ray films were not helpful in diagnosis. They could never have been separated, for autopsy revealed only one heart and one fused liver. The mother made a good recovery and about two and one-half years later delivered a normal baby.

Longevity Studies Following Total Gastrectomy in Children with Zollinger–Ellison Syndrome

S D WILSON, MD, W J SCHULTE, MD, and R C MEADE, MD, The Medical College of Wisconsin, Milwaukee, Wis: *Arch Surg* 103:108–115 (Aug) 1971

Fifteen children with islet-cell tumor(s) of the pancreas and ulcer diathesis (Zollinger–Ellison syndrome) were collected in a tumor registry established to study pathophysiology and natural history of this syndrome. Eight children had less than total gastrectomy and six of these died. Five died from complications of recurrent ulcerations. All seven children with total gastrectomy remain alive and well. Metastatic or multiple tumors or both were present in all seven at the time of total gastrectomy. Followup bioassay or gastrin radioimmunoassay studies were performed in six of the seven patients. Serum gastrin levels remained elevated for periods of 5 and 11 years in two patients. Presumably gastrin-producing tumor remains in those patients. One patient with increased gastrin six years after total gastric resection now has low levels after eight years. Two other patients have progressively lower levels each year following total gastrectomy. Results from longevity studies in this group of young patients with the Z-E syndrome support the concept that total gastrectomy, combined with tumor excision when possible, is the preferred treatment for patients harboring ulcerogenic pancreatic tumors. Observations of the tumor(s) and gastrin levels appear to indicate that tumor does regress in some patients after total gastrectomy. However, some patients continue to harbor their islet-cell lesions for many years and show no apparent effects from long-term "hypergastrinism." □

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Apparent Cardiomegaly Caused by Thymic Cyst

By Kenneth A. Hoose, MD
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IT IS NOT COMMON to mistake a thymic cyst for cardiomegaly.[1-3] However, in rare instances the location of a cyst is such that it simulates cardiac enlargement. Diagnosis in such circumstances is usually arrived at by ruling out an intrinsic cardiac lesion and histologic demonstration of thymic tissue. The following case report illustrates quite strikingly the impossibility of establishing a diagnosis short of surgical exploration.[3-7]

Case Report. A 21-year-old apprentice machinist was admitted to a university hospital for investigation of what appeared to be a large heart.

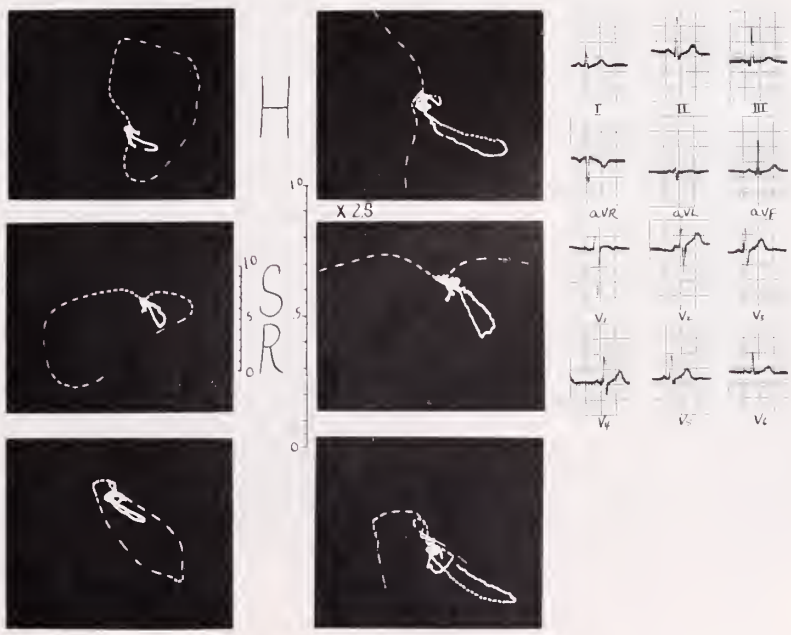
He was well until three months before admission when he suddenly experienced sharp left upper chest pain, nonradiating, and uninfluenced by respiration or cough. This episode lasted three to four hours and was not accompanied by fever, cough or dyspnea. The involved area was found to be tender and because of the pain he consulted his local physician the following day. The chest roentgenograms revealed a greatly enlarged cardiac silhouette. He was therefore admitted to his local hospital and then transferred to the university hospital for further investigation.

Physical examination produced no positive findings. The blood pressure was 140/80 mm Hg. The point of maximal cardiac impulse was located in the fifth intercostal space within the midclavicular line. The heart sounds were normal. There were no murmurs.

Laboratory tests revealed a hematocrit reading of 47%, with a white blood cell count of 8,400 per cu mm with 75% neutrophils, 3% band forms, 3% eosinophils, 18% lymphocytes, and 1% monocytes. The urine was normal.

Both electrocardiogram and vectorcardiogram taken on admission (Fig 1) were normal. An anteroposterior x-ray film of the chest showed marked enlarge-

Fig. 1—The normal electrocardiogram and vectorcardiogram recorded in this case.



From Cardiovascular Research Laboratory, Departments of Medicine and Surgery, University of Wisconsin Medical School, Madison.

Doctor Hoose is a postdoctoral fellow in medicine; Doctor Kroncke, an assistant professor of surgery; Doctor Dacumos, an assistant professor of surgery; and Doctor Bittar, an assistant professor of medicine.

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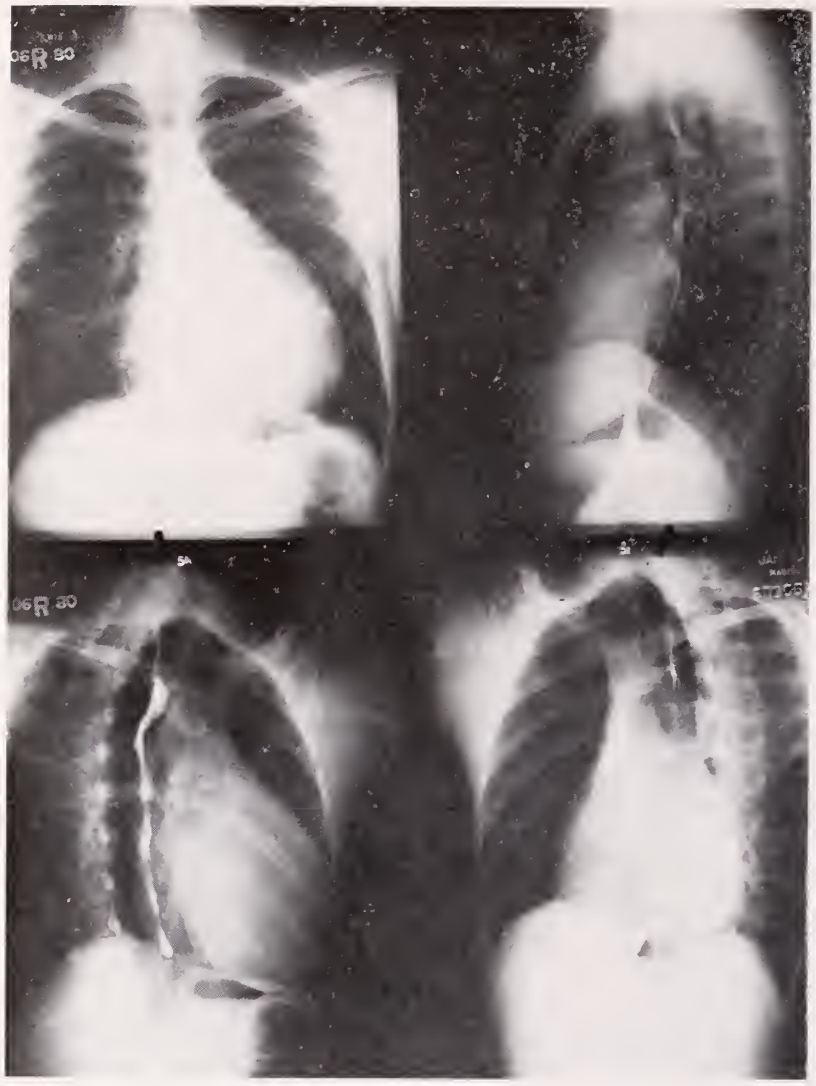

Fig. 2—Four views of the heart showing cardiomegaly.

ment of the heart. The lung fields were clear.

Fluoroscopic examination led to the conclusion that the apparent cardiac enlargement was due to a mediastinal mass. The mass appeared to be partly in the posterior mediastinum. As shown in Figure 2, the mass was located in the four views of the heart taken on the same day.

An echocardiographic study showed that there was a 3–4 cm separation between the posterior wall of the heart and the outer edge of the mass, suggesting a fluid-filled structure. This was partially confirmed by the technecium 99 m scan of the heart performed on the third hospital day. A large area of decreased uptake of radioisotope extending along the entire left cardiac border measuring 12 x 6 cm was detected. The fact that the area of decreased uptake did not cover the entire cardiac border was evidence against the possibility that this was a pericardial effusion.

In order to rule out the possibility of a cardiac abnormality associated with this mass, an angiographic study was done by injecting contrast material into the right atrium. There appeared to be evidence of "draping" of the parenchymal branches of the left pulmonary artery over and around a large mediastinal mass, as indicated by Figure 3. There was no evidence of amputation,

Fig. 3—Angiographic films of portions of the left and right side of the heart showing the major segment of the mass in the left thoracic cavity. There appears to be evidence of "draping" of the parenchymal branches of the left pulmonary artery over and around this mass.

filling defects or mass on either side of the heart.

The preoperative diagnosis was a pericardial cyst. At surgery a cyst adherent to the pericardium but lying in the anterior mediastinum and around to the left side of the pericardium was found. It was green in color and filled with 700 ml of straw-colored fluid and running through its middle were the left vagus and phrenic nerves.

Pathological examination showed a trabeculated cyst wall, with lymphocytes and Hassal's corpuscles (Fig 4), hence the diagnosis of thymic cyst.

There were no postoperative complications and the patient was discharged on the 21st day. Follow-up anteroposterior x-ray film of the chest is shown in Figure 5.

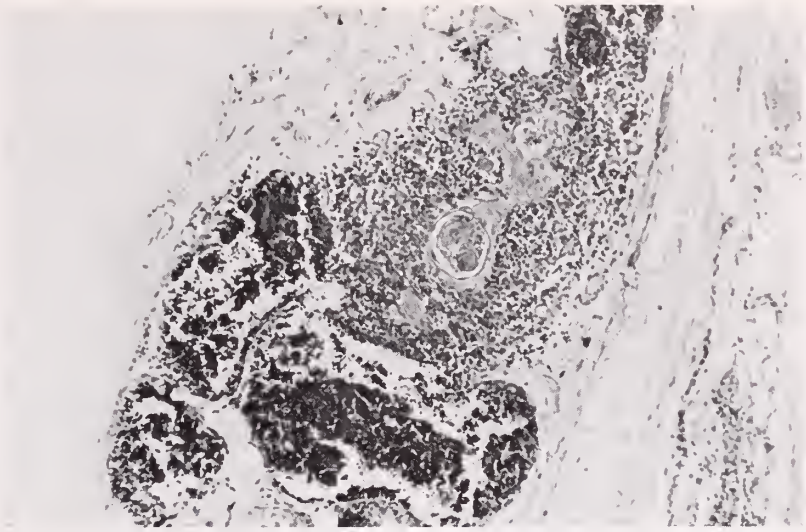

Fig. 4—High-power view of a portion of the wall of the cyst. Lymphocytes and Hassal's corpuscles are pathognomonic of the thymic cyst.

Comment. It is rare for a thymic cyst to simulate cardiomegaly.[1-3] This is because a thymic cyst usually appears as a smaller anterior mediastinal mass.[8-10] It is obviously essential to differentiate these lesions from malignant tumors.[8] Although roentgenologic features such as smooth borders of the mass and its cystic appearance are suggestive of a benign lesion, surgical exploration is necessary to accurately establish the diagnosis. Pericardial or dermoid cysts are more likely to present with abnormalities of the cardiac silhouette.[8-11] Clinical manifestations may not offer any help in distinguishing preoperatively between benign and malignant tumors of the mediastinum, as in this case. However, it should be remembered that malignant tumors are more likely to show rapid growth and to give rise to constitutional symptoms, including pleural effusion, obstruction of the superior vena cava, and paralyses of adjoining nerves.[8]

Fig. 5—Postoperative anteroposterior chest film showing a normal cardiac shadow.

Summary. A large thymic cyst in a 21-year-old man is described. Attempts at a diagnosis of the lesion masquerading as cardiomegaly prior to surgical intervention and excision of the lesion failed to provide an exact diagnosis.

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A Case of Multiple Primary Carcinomas of the Head and Neck

By Glenn H. Franke, MD
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Donald M. Levy, MD
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MULTIPLE PRIMARY CARCINOMAS pose a challenging problem to the physician particularly when all originate in the same general anatomic location. Because of the relative infrequency of this occurrence, the following case should be of interest.

Case Report: A 66-year-old man presented in 1965 with a one-year history of bilateral neck swelling (Figs 1A and 1B). Examination revealed numerous large confluent aggregations of lymph nodes in the neck and axillae with moderate enlargement of the liver. Biopsy of a cervical node in May 1965 disclosed histological changes of lymphosarcoma. His blood cell count and sedimentation rate were normal. He was treated with radiotherapy with excellent response. There was significant regression of lymph nodes in all chains (Fig 1C). The sedimentation rate rose briefly to 50 mm per hour and within three months had again returned to normal, and his complete blood cell count remained normal. He was followed carefully at regular intervals and over the next six months was asymptomatic. Physical findings were not remarkable except for several small discrete nodes in the groin and an equivocal nodule in the left side of his neck. In February 1966, he developed a small lesion on the left side of his upper lip which on biopsy was initially thought to be malignant melanoma but on further slide review proved to be a hemangioendothelioma (Figs 2A and 2B). In April 1966, this was surgically treated with wide excision and closure by a nasolabial flap. His postoperative course was satisfactory; and although he still had several small nodes in both inguinal chains, there was no evidence of metastatic hemangioendothelioma or recrudescence of the previously treated lymphosarcoma. In August 1967, he developed a lesion on the left side of his forehead. This was excised and proved to be an infiltrating squamous cell carcinoma (Fig 3). About May 1967, he began to develop several small nodes on both sides of his neck. The one most prominent was the left digastric node which slowly increased in size and was of a rather rubbery soft consistency. As this lesion slowly enlarged, it was thought to be a recurrence of the lymphosarcoma. Further x-ray therapy was given with very slight regression of this mass.

In December 1967, a left suprahyoid neck dissection was carried out. At the time of surgery the microscopic sections of the tumor revealed hemangioendothelioma. Because of the extent of tumor invasion it was impossible to remove all of the neoplasm. (Figs 4A and 4B)

Initial postoperative course was not remarkable, but there

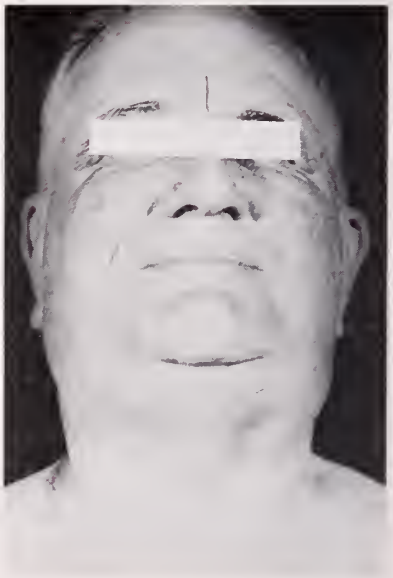

Fig. 1A—Patient showing bilateral cervical lymphadenopathy due to lymphosarcoma.

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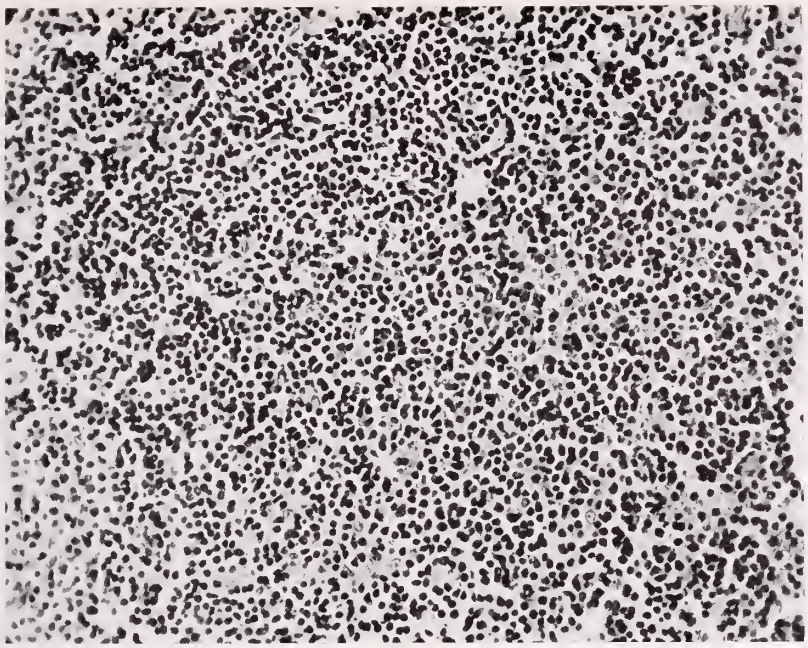

Fig. 1B—Microscopic section showing lymphosarcoma neck.

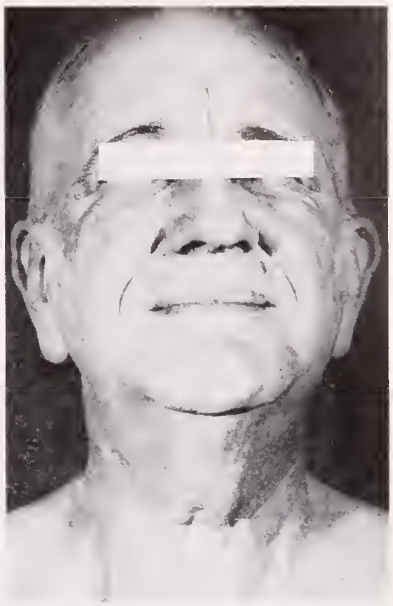

Fig. 1C—Patient following radiation therapy for lymphosarcoma with regression cervical nodes.

Fig. 2A—Patient's upper lip showing hemangiosarcoma.

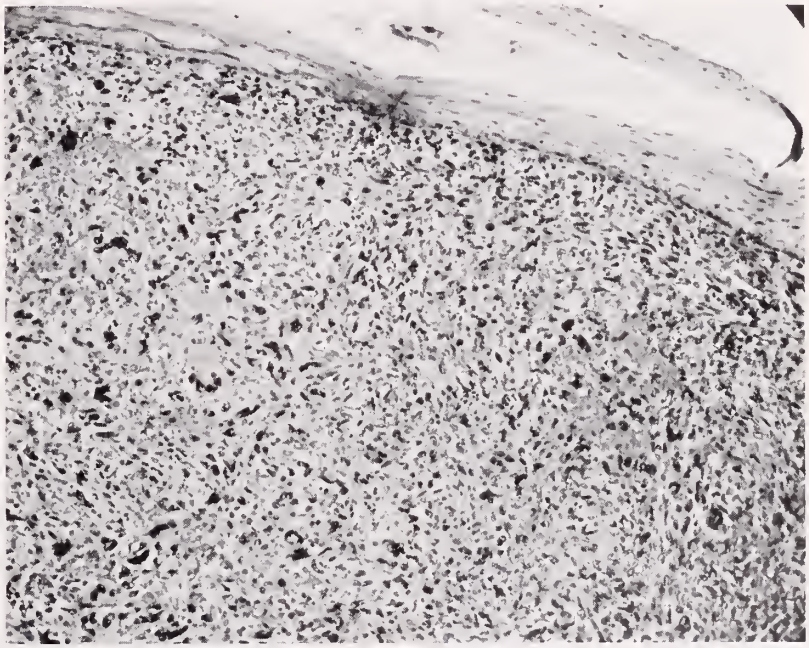

Fig. 2B—Microscopic section of hemangiosarcoma upper lip.

was residual tumor beneath the angle of his mandible on the left side. Thereafter he developed progressive enlargement of the residual tumor and ulceration and necrosis of the overlying skin. In February 1968, a chest x-ray film revealed bilateral nodular infiltrates suggestive of metastatic tumor. He received an unsuccessful trial of cyclophosphamide (Cytoxan®) and actinomycin D. He died March 22, 1968, three years after the onset of lymphosarcoma. Autopsy findings showed metastatic lymphoma of mesenteric and paravertebral lymph nodes and metastatic hemangiosarcoma of the lungs as well as terminal bronchopneumonia.

In summary, then, this individual was treated for multiple cancers, all of which were in the same general region of the head and neck beginning with lymphoblastic lymphosarcoma in the cervical glands followed by hemangioendothelioma of the upper lip and squamous cell carcinoma of the forehead, and ultimately developing metastases of the hemangiosarcoma to the submandibular lymph nodes.

Review of Literature. Billroth,[1] over 100 years ago, is usually credited with the first report of more than one primary carcinoma in a single patient. In spite of these early observations this phenomenon was considered rela-

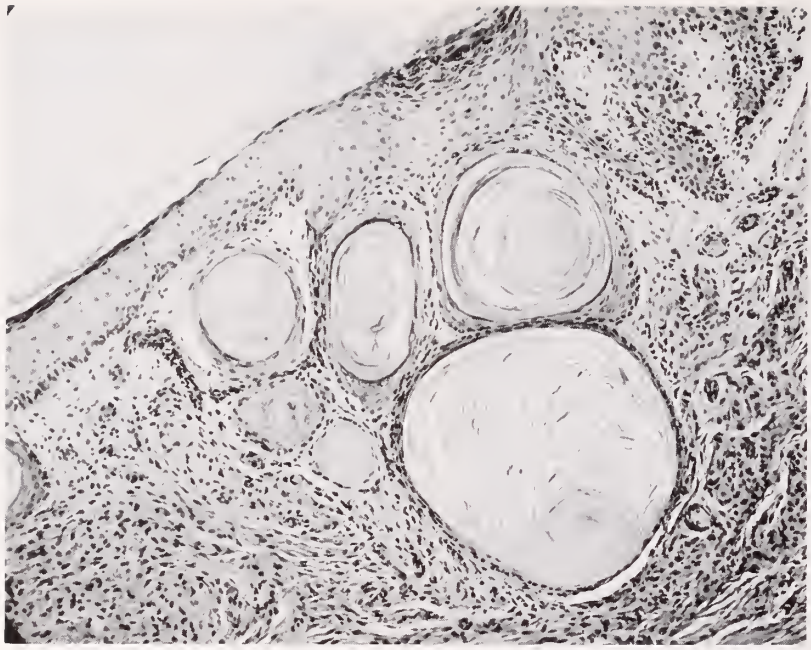

Fig. 3—Microscopic section infiltrating squamous cell carcinoma forehead.

tively uncommon until various investigators began taking a closer look at the problem. Moertel, Dockerty, and Baggenstoss[2] reviewed 1,909 cases of multiple cancer at the Mayo Clinic from 1944 to 1953. This group of patients represented 5.1% of all cancer patients admitted during that period. Of this number 1,049 or 2.8% had multiple primary cancers of different tissues of origin. They found no consistent pattern. The risk appeared to be governed more by age and family history than any factor other than the possible effect of treatment, such as lymphangiosarcoma developing at the site of post mastectomy lymphedema or the leukemogenic effect of x-ray treatment. In reviewing the possible association of various types of neoplasms there were no consistent patterns other than a tendency to find a greater incidence of breast carcinoma in patients who have had previous carcinoma of the uterus. There also seems to be some increased incidence of cancer in the oral cavity and larynx in patients with previous carcinoma of the lung as well as association between cancer of the bladder and prostate. In 1966, Spratt and Hoag[3] reported a study including 1,130 patients with colorectal cancer, 710 with mammary cancer, 167 with chronic leukemia, and 485 lymphoma patients and compared them with 1,000 consecutive patients without neoplasms at the time of their first visit. Conclusions were that the cancer rate increased with age but prior cancer neither increases nor decreases the risk of developing additional neoplasms. These findings are somewhat at variance with those reported by other investigators. Campbell et al[4] studied 2,594 cancer patients of which 165 (6.4%) had multiple primary cancers. In 1968, Caselnova et al[5] reviewed reports of patients with four or more primary malignant neoplasms. At that time they were able to collect 16 cases in the literature and added one more case of their own. It was noted that in 70% of the reported cases it was the second or third tumor which was the cause of death and not the primary or first-discovered carcinoma.

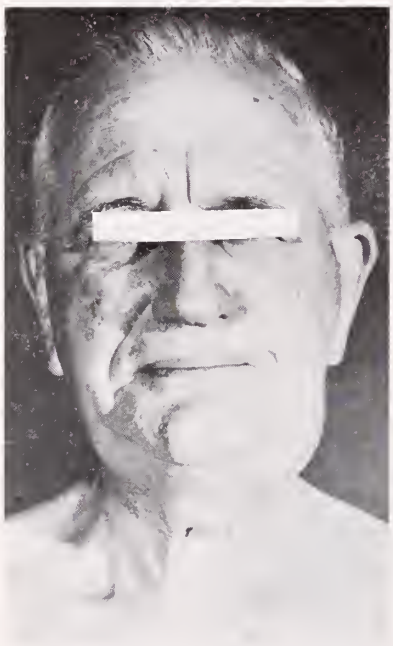

Fig. 4A—Recurrent cervical mass left side of neck.

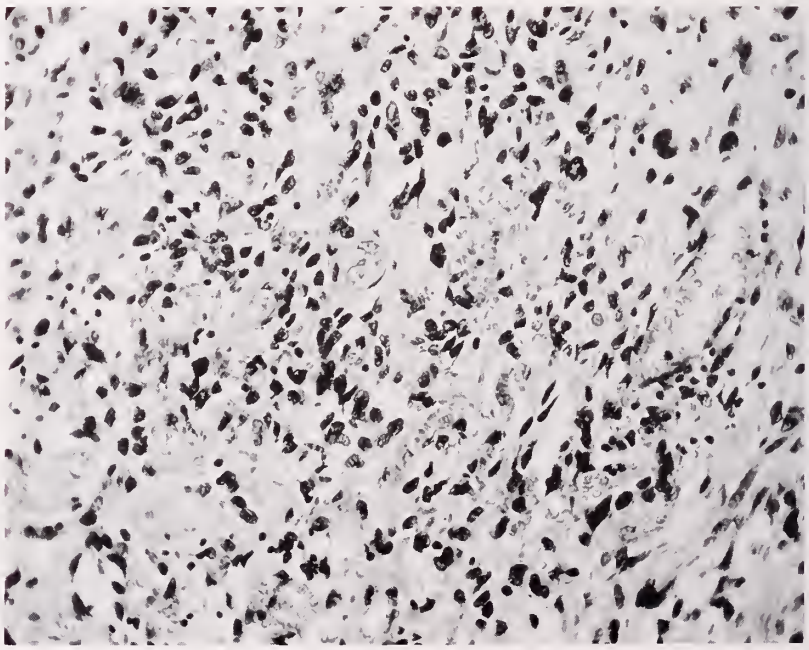

Fig. 4B—Microscopic metastatic hemangiosarcoma to left upper cervical lymph node.

Several investigators have attempted to correlate the incidence of multiple carcinomas with ABO blood groups and divergent opinions have emerged. A preliminary study was reported by Fadhli et al[6] in 1963. In a survey of 123 white patients with multiple primary carcinomas they found a significantly increased incidence of type A blood. This theory was laid to rest, however, by Holey et al[7] in 1966 when a study of 1,126 cases of multiple malignancies revealed no difference in blood type from the distribution of normal population.

Summary. A case of a patient who developed multiple primary carcinomas of the head and neck is presented. The tumors included lymphosarcoma, hemangioendothelioma, and squamous cell carcinoma. The case emphasizes the importance of careful investigation and treatment of all neoplasms since 5% of all patients with cancer will develop two or more primary malignancies and 70% of these individuals die not of the first but of the subsequent malignant disease.

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Mental Retardation in Four Offspring of Hyperphenylalaninemic Mother

E S BROWN, MD and the late H A WAISMAN, MD, Joseph P. Kennedy, Jr., Lab, University of Wisconsin, Madison, Wis: *Pediatrics* 48:401–410 (Sept) 1971

Mental retardation is known to occur in most offspring of mothers with phenylketonuria if maternal plasma phenylalanine levels are greater than 20 mg/100 ml. Several hyperphenylalaninemic mothers have had normal children, although they have had plasma phenylalanine levels of 8 to 10 mg/100 ml. Since plasma phenylalanine levels between 10 and 20 mg/100 ml often cause no mental retardation in the affected individual, it seemed possible that such maternal levels might not be harmful to the offspring. However, this paper describes a mother with plasma phenylalanine levels of 15 to 17 mg/100 ml and normal IQ who had 4 educable retarded offspring. They were all microcephalic at birth, but were of normal weight and length. All had minor congenital anomalies. We therefore recommend that women with plasma phenylalanine levels greater than 15 mg/100 ml should not have children. □

Effect of Azathioprine on Renal Histology and Function in Lupus Nephritis

W D SHELP, MD, J M B BLOODWORTH, JR, MD, and R E RIESELBACH, MD, University of Wisconsin Medical School, Madison, Wis: *Arch Intern Med* 128: 566–573 (Oct) 1971

The effectiveness of azathioprine was assessed in a longitudinal study of 12 selected patients with varying degrees of lupus nephritis. All had substantial histological evidence of disease (five with lupus glomerulitis and seven with lupus glomerulonephritis), and eight had an initial glomerular filtration rate of less than 80 ml/min 1.73 sq m. Clinical improvement or stability was observed in all patients and confirmed by serial renal clearance studies and protein excretion rates. Histologic evidence of acute glomerular involvement diminished in all patients, in association with the evolution of glomerulosclerosis. Seven patients were able to discontinue corticosteroids without clinical deterioration. Eight patients with initial renal insufficiency remained clinically stable with a mean survival of 32.5 months. Thus, azathioprine appears to offer considerable therapeutic benefit to selected patients with lupus nephritis. □

Oxolinic Acid, New Chemotherapeutic Agent in Treatment of Urinary Tract Infection

P. O. MADSEN, MD, and P. R. RHODES, MD, Veterans Administration Hospital, Madison, Wis: *J Virol* 105:870–872 (June) 1971

A new chemotherapeutic agent, oxolinic acid, chemically closely related to nalidixic acid (Neg-Gram®) was tested in the treatment of chronic urinary tract infections in 171 patients infected with 216 isolated microorganisms, with many complicated by obstruction and stones. The drug was well tolerated with a few side effects in patients with normal renal function as well as patients with impaired renal function. Oral administration of the drug twice daily resulted in continuous high urine concentrations. The drug was safe and efficient, showed no accumulation in the blood in patients with impaired renal function and did result in high urine concentrations, also in patients with poor renal function. During treatment it eliminated from the urine 79 percent of gram-negative microorganisms sensitive to oxolinic acid and cured 33 percent of these chronic infections. The high urine concentrations and low serum concentrations will probably limit the usefulness of this drug to urinary tract infection. □

BONE MARROW TRANSPLANTATION

A Solution to Renal Allograft Rejection in Adult Canines

By J. L. Hussey, MD
Madison, Wisconsin

DR. J. L. HUSSEY presented the winning resident–intern paper at the 130th Annual Meeting of the State Medical Society of Wisconsin, May 11, 1971, in Milwaukee. He was given $100 as the Harry Beckman Award.

THE SIXTH DECADE of the twentieth century probably will be recorded in medical history as the "Transplantation Decade." No procedure in the last 100 years has so stimulated the imagination of both physician and the lay public as has organ homografting.

Although vigorously pursued initially as a therapeutic panacea, the procedure as now employed enjoys scant success. In analyzing the failure of organ transplantation, it appears that rejection and the therapy thereof are overwhelmingly responsible for the dismal outlook of these procedures as they are now performed.

Because of the severe limitations of the present procedure, we formed and studied the following hypothesis: Substitution of the donor immune system for that of the recipient prior to major organ homografting prevents rejection from occurring and obviates the use of immunosuppressive agents.

Materials and Methods. Ten pairs of adult mongrel dogs and their controls were studied via the following procedures:

1. Donor–Recipient Selection
2. Recipient Immunodestruction
3. Marrow Transplantation and Leukapheresis
4. Renal Allografting

Donor–Recipient Selection: Dogs were selected for the procedure on the basis of histocompatibility via Mixed Leucocyte Culture (MLC) and serotyping techniques. Whenever possible, sex opposite pairs were used.

Recipient Immunodestruction: Recipient animals were administered 700 rads of total body irradiation (TBI) at a dose rate of 25–100 r/min.

Marrow Transplantation and Leukapheresis: Donor marrow is procured by aspiration of both humeri and femurs. A flexible plastic cannula is inserted through the jugular vein into the superior vena cava for leukapheresis. The marrow is filtered, viability determined and the cells counted before administering to the recipient intravenously.

Daily, for three days following the marrow procurement, leukapheresis is performed and administered intravenously to the recipient. Following the marrow graft, animals receive iron dextran injection (Imferon®), vitamin B_{12}, and folic acid intramuscularly on a prescribed schedule. The animals are isolated for a two-week period and the complete blood counts are obtained at periodic intervals. About one month following transplantation, cytogenetic analysis is performed on those animals with sex opposite donors. Control animals are treated identically to recipient animals, except that they receive no marrow graft.

Renal Allografting: Donor renal arteriograms are obtained to assure a single renal artery, a necessity to transplantation. The selected donor kidney is removed and perfused for four minutes with Ringer's Lactate Solution, containing 60 mg of papaverine and 10,000 units of heparin. Immediately the kidney is transplanted into the contralateral groin of the recipient. During the procedure mannitol is administered intravenously to promote diuresis. Postoperatively, ampicillin and acetysalicylic acid (ASA) are administered empirically and urinary functions are monitored.

Results.

(1) All of the control animals died between 4 and 10 days postirradiation.

(2) Successful marrow grafts were achieved in all ten experimental animals.
   - (a) Three recipients died of pneumonia.
   - (b) Two animals died of graft versus host disease (gvh).
   - (c) One animal died of unexplained causes, possibly marrow rejection.
   - (d) Four animals remain alive and well 120 to 270 days post marrow transplantation with no evidence of disease.
     - (1) Two of these animals are proven chimeras via cytogenetic analysis.
     - (2) Three of the animals received renal homografts and are presently alive and well without immunosuppres-

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sive agents for 90 to 150 days post renal grafting. There is no clinical or laboratory evidence of rejection, and these animals are living a normal existence.

Discussion. Histocompatibility is very important to successful organ grafting. Mixed Leucocyte Culture developed by Dr. Fritz Bach and modified for animal use by Dr. William Kisken provides a sensitive test for tissue compatibility in animals. Serotyping technique, which employs a panel of known specific antisera, also is used and seems to correlate well with mixed leukocyte culture.

Sex opposite pairs were selected whenever histocompatibility permitted. Cytogenetic analysis to determine chimeras was performed on all sex opposite pairs approximately one month post marrow graft. Female to male grafts were ideal as X chromosomes are more readily recognized than Y chromosomes. Analysis of recipient leukocytes following transplantation revealed all donor cells, proving that the animal was chimeric. Interestingly, total body irradiation always produced "complete chimeras," as opposed to "mixed chimeras" often obtained with drug immunosuppression. Dose rate is important in immunodestruction. By using a high dose rate we achieved complete immunodestruction, needing only 700 r of total body irradiation. This eliminated the toxic side effects of high dose irradiation. Others have used 1200 r total body irradiation at a much lower dose rate to achieve the same effect.

As all control animals died, the radiation dose was deemed adequate to destroy the hemopoietic system. However, animals marrow grafted survived the period of leukopenia without succumbing to toxic effects of radiation.

Leukapheresis offers three theoretical advantages:

(1) In the dog, stem cells circulate peripherally and enhance the marrow graft via leukapheresis.

(2) Immunodestruction places the animal at the mercy of environmental pathogens. Infused white blood cells may offer a temporary defense mechanism throughout this period.

(3) Finally, immunocompetent cells from the donor may provide an endogenous immunodestructive capacity acting to destroy residual host immunocompetence not eliminated by irradiation.

We do not know whether these theoretical advantages are fact. However, we believe that only the immature cells, i.e., the stem cells, are capable of taking up and maintaining unmolesting residence in genetically dissimilar individuals. We believe that the mature immunocompetent cells transplanted during marrow engraftment and leukapheresis are responsible for graft versus host (gvh) disease. This disease, evidenced by anorexia, diarrhea, hair loss, skin rash, runting, electrolyte imbalance, septicemia and death, is a severely limiting factor in bone marrow transplantation. We believe that elimination of mature immunocompetent cells will prevent gvh disease. It is known that immature cells accept foreign protein and will maintain tolerance to that protein, even after their maturation, suggesting that they can be "programmed" to tolerance.

Any animal who failed to achieve a white blood cell count greater than 1,000 cells per cubic millimeter did not have a successful graft and hence, did not survive. Most of the animals undergoing 700 r of total body irradiation reached white blood cell count below 800 cells per cubic millimeter. Any animal who could demonstrate a white cell count above 1,000 cells per cubic millimeter after 700 rads (TBI) had a successful graft and barring any unforeseen complications such as infection or graft versus host disease would go on to survive.

Renal allografting was chosen to test the system for the following reasons: (1) They are quickly and easily performed in dogs of this size. (2) Renal function can be easily and accurately determined. (3) As the kidney is a paired organ, the donor could be salvaged for further study. In experienced hands, the procedure can be done quickly. Our average ischemic time is 23 minutes. The use of mannitol as an osmotic diuretic was implemented on a purely empirical basis. Likewise, the administration of ampicillin and aspirin were on an empirical basis: ampicillin as a prophylactic antibiotic and acetylsalicylic acid to prevent suture line thrombosis. Although we had no incidences of infection or graft failure, we have no objective means of determining whether they were of any real benefit.

It was exciting and gratifying to see that renal functions remained completely normal long after the expected period of rejection in animals not administered immunosuppressive agents. Histocompatible animals will reject kidneys in 28 days if not immunosuppressed. Animals with marrow grafts prior to renal grafting, have yet to evidence rejection, some five times past the expected period of rejection.

The abolition of rejection indicated with this procedure is promising. If such a procedure could be employed with acceptable morbidity and mortality on humans, the field of transplantation could take on new meaning. Perhaps, by a procedure similar to this organ transplantation will become a common and an excellent mode of therapy.

Conclusion. This work suggests several conclusions: (1) Transplanted immune mechanisms prior to kidney grafting will prevent homograft rejection. (2) As we have transplanted only marrow mediated immune mechanisms, it appears that organ rejection is dependent upon marrow derived immunocompetent cells. (3) Graft versus host disease (gvh) is seen in animals even under the most favorable situations as determined by present histocompatibility methods and is a serious barrier to marrow grafting. □

A Follow-up Study of Aortic Valve Homografts for Two to Four-and-one-half Years

W P YOUNG, MD, G M KRONCKE, MD, G C DACUMOS, JR., MD, and G G ROWE, MD, University of Wisconsin Medical Center, Madison, Wis: *Ann Thorac Surg* 12:154–162 (Aug) 1971

Fifty-two patients underwent replacement of their aortic valves with homografts at the University Hospitals between March 1966 and September 1968. Since then they have had follow-up studies at regular intervals. There were no intraoperative deaths and the results have been very favorable when compared with the results in patients who have undergone replacement of the aortic valve by prosthetic valves and have been followed for at least two years. Patients with homografts have not received any anticoagulants and no emboli have been recognized. These patients were spared the weakest feature of prosthetic valves—thromboembolism and problems associated with anticoagulant therapy.

Homograft replacement of the aortic valve has not been used frequently at most medical centers because of concern regarding postoperative diastolic murmurs, technical difficulties of homograft procurement and placement, and the question of durability of the homograft.

Eighteen of 42 survivors do have diastolic murmurs but the majority of these murmurs are due to small leaks between the homograft and the recipient aortic annulus. Neither diastolic murmurs that have been present continually nor those that have appeared late have been associated with deterioration of the patient's state. All survivors remain normally active with very few taking any medication.

One patient suffered a spontaneous rupture of a homograft leaflet which was successfully replaced by another homograft at emergency surgery.

One patient developed subacute bacterial endocarditis due to a streptococcus presumably involving the homograft. Antibiotic therapy rendered a cure with no residual murmur.

In the authors' experience, replacement of the aortic valve by homograft is very feasible, diastolic murmurs associated with homografts have not led to deterioration, and homografts have been as durable as aortic prosthetic valves. Homografts remain the replacement of choice in many situations.

(The follow-up to date, now 3–5½ years, reveals change in only one patient. Subacute bacterial endocarditis, resulting from dental work not covered by antibiotics, destroyed a homograft which was successfully replaced by another homograft, decreasing the number of patients with diastolic murmurs to 17.) □

Nitrazepam: Provided anticonvulsant activity in 11 of 15 children with minor motor seizures with 6 receiving complete relief. The dosage ranged from 0.3 mg to 2.2 mg per kg body weight. In another 16 children with miscellaneous seizures, 9 were improved, but only 1 completely relieved. By Dr. J. E. Jan and associates, Vancouver, British Columbia, Can.—AMERICAN DRUGGIST, Aug. 9, 1971 □

Significance of Cytoplasmic Microtubules in Lupus Nephritis

J C GARANCIS, MD, et al, Medical College of Wisconsin, Milwaukee, Wis: *Amer J Path* 64:1–12 (July) 1971

Thirty-one renal biopsies from 17 SLE patients with lupus nephritis were examined by electron microscopy. Skin biopsies and peripheral leukocytes were also examined from two patients. Seventy-five renal biopsies from non-lupus patients were used for comparative study. The non-lupus group consisted of 35 adults and 40 children.

Undulating microtubules, measuring about 200–250 A in diameter, were observed in the endothelial cytoplasm of glomerular and peritubular capillaries in all SLE patients. The undulating nature was most apparent in longitudinal sections. Seemingly, by the process of intertwining, these microtubules formed various sized clusters which were obvious while scanning at a low magnification (×600). The clusters of microtubules were considerably larger and more numerous in renal biopsies procured during early, active stage of SLE, and also during relapse. The clusters were fewer and smaller in renal biopsies obtained while patient in remission. Similar cytoplasmic microtubules were observed in the endothelial cells of skin capillaries and arterioles. Furthermore, the microtubules were more frequent in erythematous areas than in normal skin. Of the 75 non-lupus patients, small clusters of cytoplasmic microtubules were observed in renal biopsies of three adults with the following clinical diagnosis:

1. Preclampsia
2. Membranous glomerulonephritis
3. Rheumatoid arthritis with nephrotic syndrome

The microtubules were also observed in 13 children, of which 11 had nephrotic syndrome and two proliferative glomerulonephritis with proteinuria.

The cytoplasmic microtubules have been referred to as virus-like particles by some investigators. These cytoplasmic microtubules may be of viral origin because of their morphological similarity to mixoviruses. More convincing evidence in favor of this concept is the recent work of Hollinger et al. They demonstrated in SLE patients high serum antibody fibers to viral antigens of measles, rubella, parainfluenza 2 and 3, and riovirus type 2. Occasionally small clusters of the cytoplasmic microtubules also have been observed in other renal diseases. However, much higher incidence rate and larger size of these clusters in glomerular capillaries of SLE patients may be of early diagnostic value. □

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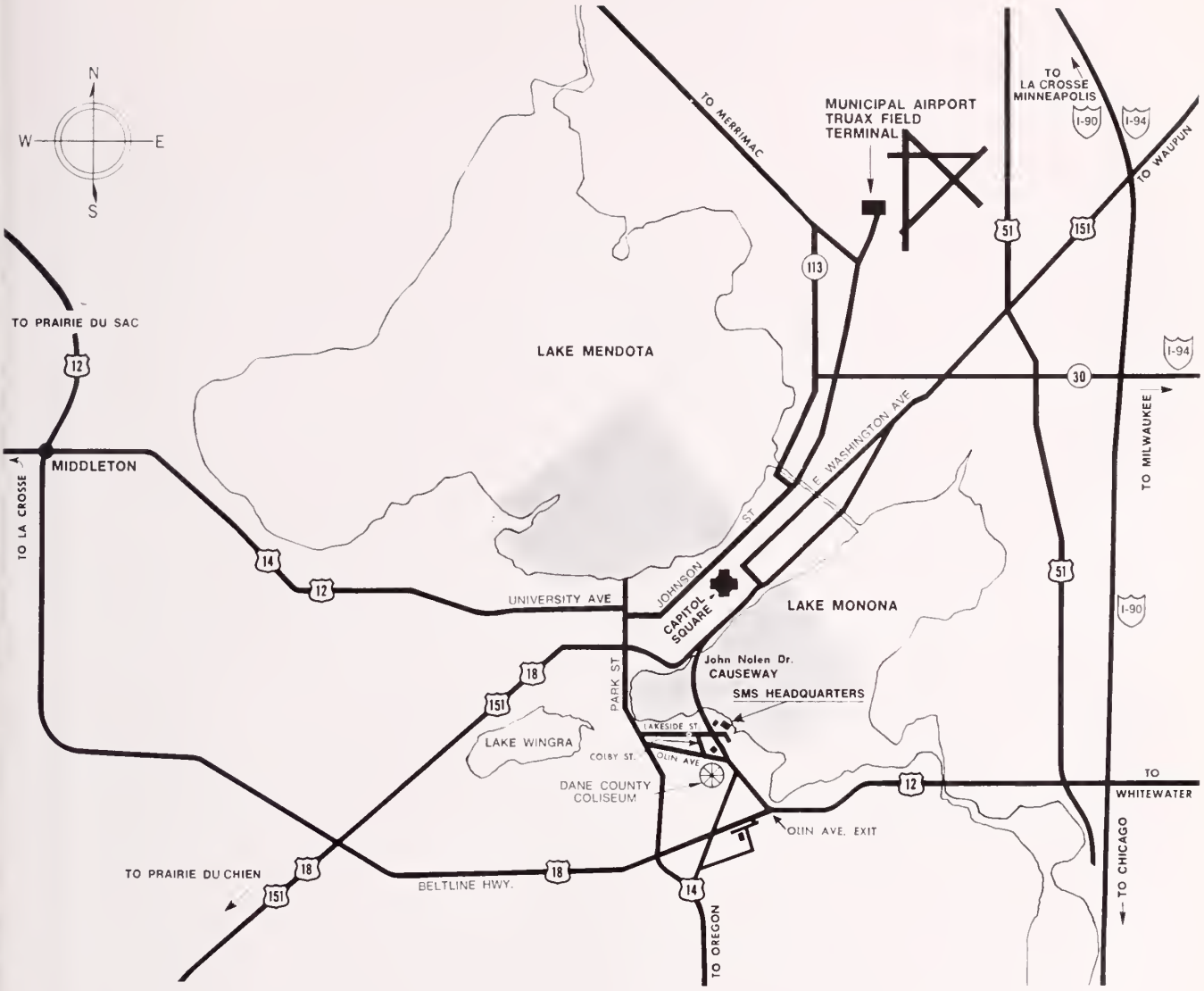

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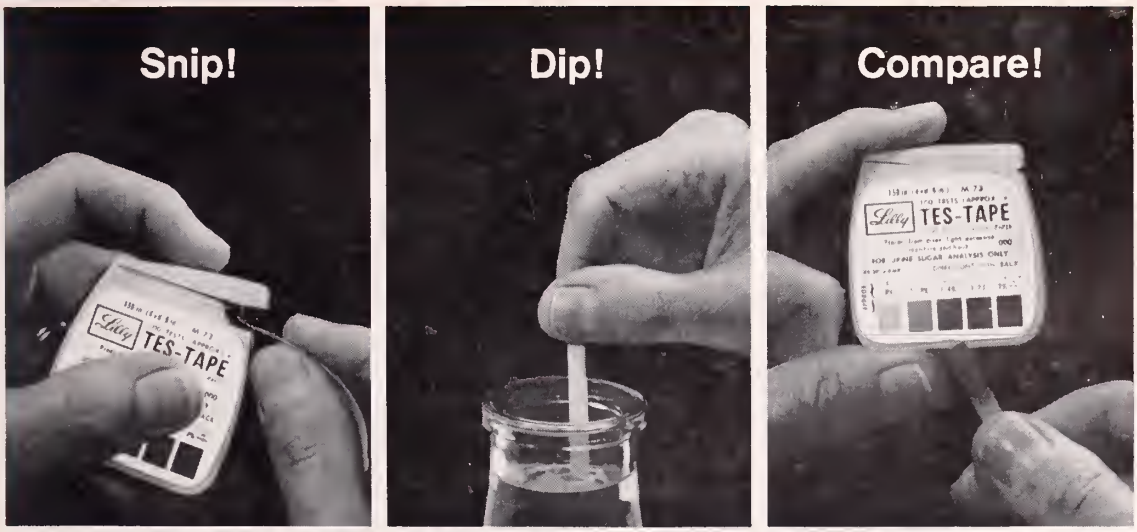

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References: 1. Frost, J. D., Jr.: "A System for Automatically Analyzing Sleep," Scientific Exhibit presented at Clinical Convention, A.M.A., Boston, Nov. 29-Dec. 2, 1970, and Aerospace M.A., Houston, April 26-29, 1971.
2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, N.J.

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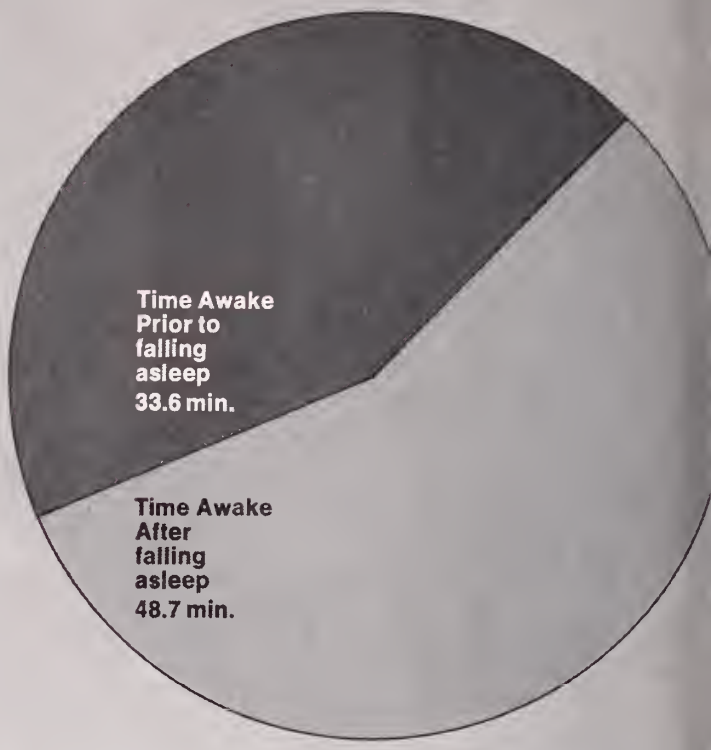

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TWO ACTIVE COMPONENTS
give "four season" sufferers dependable relief

Chlorpheniramine Maleate dries runny noses and eyes, quiets sneezing, wheezing, soothes itching and reduces postnasal drip—all with a particularly low index of side effects such as drowsiness.

Pseudoephedrine HCl: decongests throughout *entire* respiratory tract, opening nasal passages, dilating bronchioles, relaxing "tight chest"—as effectively as ephedrine, but with much less CNS or cardiovascular stimulation.

COMPOSITION: Each tablet or 10 cc. (2 teaspoonsful) of liquid contains:

Chlorpheniramine Maleate ..... 4 mg.
Pseudoephedrine HCl ..... 25 mg.

Each Isoclor Timesule contains:

Chlorpheniramine Maleate ..... 10 mg.
Pseudoephedrine HCl ..... 65 mg.
In a special pellet form providing both prompt and sustained effect.

INDICATIONS: For relief of upper respiratory and bronchial congestion associated with: the common cold, hay fever and allergies, sinusitis, influenza, and vasomotor and allergic rhinitis.

CONTRAINDICATIONS: Sensitivity to antihistamines or sympathomimetic agents. Severe hypertension or severe cardiac disease.

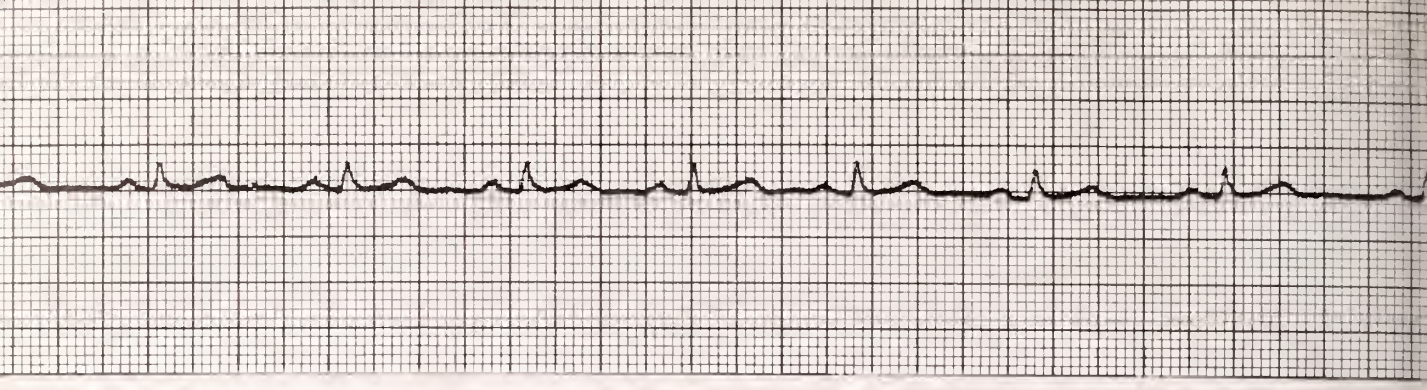
PRECAUTIONS: Use with caution in patients with hyperthyroidism. Patients susceptible to the soporific effects of chlorpheniramine should be warned against driving or operating machinery should drowsiness occur.

CAUTION: Federal law prohibits dispensing without prescription.

SUPPLIED: Tablets: Bottles of 100; Liquid: Pints and gallons; Timesules: Bottles of 50, 250, and 1000.

DOSAGE AND ADMINISTRATION:	Tablets	Liquid	Timesule
Adults:	1 q. 3-4 h.	2 tsp. q. 3-4 h.	1 q. 12 h.
Children 6-12 years:		1 tsp. q. 3-4 h.	
40-50 pounds:		¾-1 tsp. q. 3-4 h.	
30-40 pounds:		½-¾ tsp. q. 3-4 h.	
20-30 pounds:		¼-½ tsp. q. 3-4 h.	
15-20 pounds:		⅛-¼ tsp. q. 3-4 h.	

ARNAR-STONE LABORATORIES, INC.
Mount Prospect, Illinois, U.S.A. 60056
Subsidiary of American Hospital Supply Corporation



When disease is ruled out and psychic tension is implicated

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets

helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg; bottles of 100 and 500. All strengths also available in Tel-E-Dose™ packages of 1000.

ROCHE

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